PFI AND THE NHS: FINDING THE BEST EXIT

Dealing with the growing burden of the Private Finance Initiative on the NHS

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This report is a guide to the problems created in the NHS by the Private Finance Initiative and some of the potential solutions. There has been a wealth of academic work and inquiries but far less information aimed at the public. This issue must be faced as there are huge financial pressures on the NHS which can be partly relieved by maximising the amount that is spent on patient care.

The PFI is a significant burden on the finances of our hospitals at a time when the government has required that all NHS bodies make huge savings. Part of our analysis looks at how those NHS trusts with the largest debts are often those with PFI obligations.

We can also see from the well publicised events at the South London NHS Trust (now dissolved) and at other trusts, that the high cost of PFI is influencing the direction of local services. The public are being presented with plans for reconfiguration and service cuts. Alleviating the high costs of PFI is playing a part in these proposals.

In response to the sustained flow of criticism of PFI, some policy changes been made, but very little has been done to address the existing deals. This is except for the £1.5bn in government hand outs to help some of the struggling trusts to meet their PFI payments. There are no signs that these extra funds will be maintained and so more fundamental solutions must be found.

A large degree of consensus now exists about the impact of PFI. Academics, public bodies, Parliamentarians and health organisations have all looked at the evidence and agree that PFI offers poor value in comparison with the alternatives. The problems with affordability will get worse and provide a substantial burden on the generations to come. The question now is what do we do about it?

Table 1: The 15 most indebted NHS Trusts, their predicted debts for 2013-14, and whether they have PFI obligations or not

NHS Trust	Predicted Debt 2013-14 [£m]	PFI?
Barts Health NHS Trust	50	YES
Peterborough & Stamford Hospitals NHS Foundation Trust	39	YES
University Hospital of North Staffs NHS Trust / Stoke PCT	31.4	YES
South London Healthcare NHS Trust (dissolved)	24.1	YES
Bolton NHS Foundation Trust	24	
University Hospitals of Morecambe Bay Foundation Trust	24	
Mid Yorkshire Hospitals NHS Trust	20.7	YES
North West London Hospitals NHS Trust	20.3	YES
Mid Essex Hospital Services NHS Trust	19.5	YES
East Sussex Healthcare NHS Trust	19.3	
Barking Havering and Redbridge NHS Trust	17.3	YES
United Lincolnshire Hospitals NHS Trust	16.6	
The Princess Alexandra Hospital NHS Trust	16.6	
Barnet & Chase Farm Hospitals NHS Trust	16.4	YES
Sherwood Forest Hospitals NHS Foundation Trust	15.1	YES

Executive Summary

Our analysis found that ten out of the fifteen NHS trusts with the highest predicted deficits for this year – 2013/14 – have large PFI obligations (see Figure 1). We also established that in half of the ten most indebted PFI trusts the annual cost of PFI is actually taking an increasing proportion of their income.

For all of the PFI schemes the annual cost to the NHS trust increases year on year. In five years time they will be paying nearly 15% more than now and in 10 years nearly 30% more. The pressure exacted on these indebted trusts from PFI is shown by the fact that most pay between 6% and 18% of their operating income (Fig 3). So clearly PFI is a growing burden and trusts will need to keep increasing their income or, as some are already experiencing, they will face further cuts in the amount they have to spend on patients and staff.

Although the re-launch of PFI (PF2) addressed some of the concerns about future schemes, it has done little to rectify the poor value inherent in the 118 acute hospital PFI schemes that have already been completed. The National Audit Office reported that Department of Health initiatives had only found £61 million in savings on PFI in the NHS. This is just 0.09% of the total charge (unitary) left to pay across all of the schemes – a drop in the ocean.

There are workable options which could address the burden from current PFI schemes, but none have been used to any great extent. The public have been poorly served by the lack of transparency and narrow policy options offered by the political parties in response to the consensus on the problems with PFI. There are a number of options in achieving better value and a qualified taskforce should be commissioned to look at what is appropriate on a case by case basis. However consultation with the public must take place. A great deal of public money is at stake and the public should be aware and involved in the choices ahead. Lack of political commitment will hamper this process and a clear steer from the public will also help to bring the private companies to the negotiating table.

Where possible the government should seek to renegotiate the existing contracts to a point where they provide fair value. So far, attempts at renegotiation have aimed low and produced poor results within Health. Other Department have a grerater success. The Department of Transport achieved greater savings and brought some deals back in house. There is an urgent need to address these shortcomings in achieving better value for the public.

There is a fundamental link between the continued use of PFI and the attempts to fragment the NHS and introduce the market. We cannot address the financial flaws in the current system without removing the market structure and its associated incentives. Currently a winners and losers system, based on financial rewards drives a high number of hospitals towards financial failure. PFI is a part of this picture.

An omission lies at the heart of the nation's finances as PFI debts are not usually included in the national accounts and can be seen only in the balance sheets of NHS trusts. Yet clearly the government does act as guarantor. Rectifying this situation would help to offer the public a much more accurate picture of the true cost of PFI. Scrutiny on behalf of the public has been poor. For example the treasury does not track the way PFI debt is being sold on, often many times over. Profits from this secondary market are large and far outweigh the financial risk taken by investors. The public are also largely in the dark about the additional loss to the public purse from that companies that invest in PFI and avoid tax by being domicile in tax havens.

There is a wealth of evidence showing that many PFI contracts offer a very poor deal, providing huge profits for investors that far outweigh the risks. Therefore the economic and moral case for taking action is very strong. In fact the current financial pressures on the NHS mean we cannot afford not to take action on PFI. By addressing the problems with PFI and removing the market we could channel more funding towards patients and help to secure the future of our NHS.

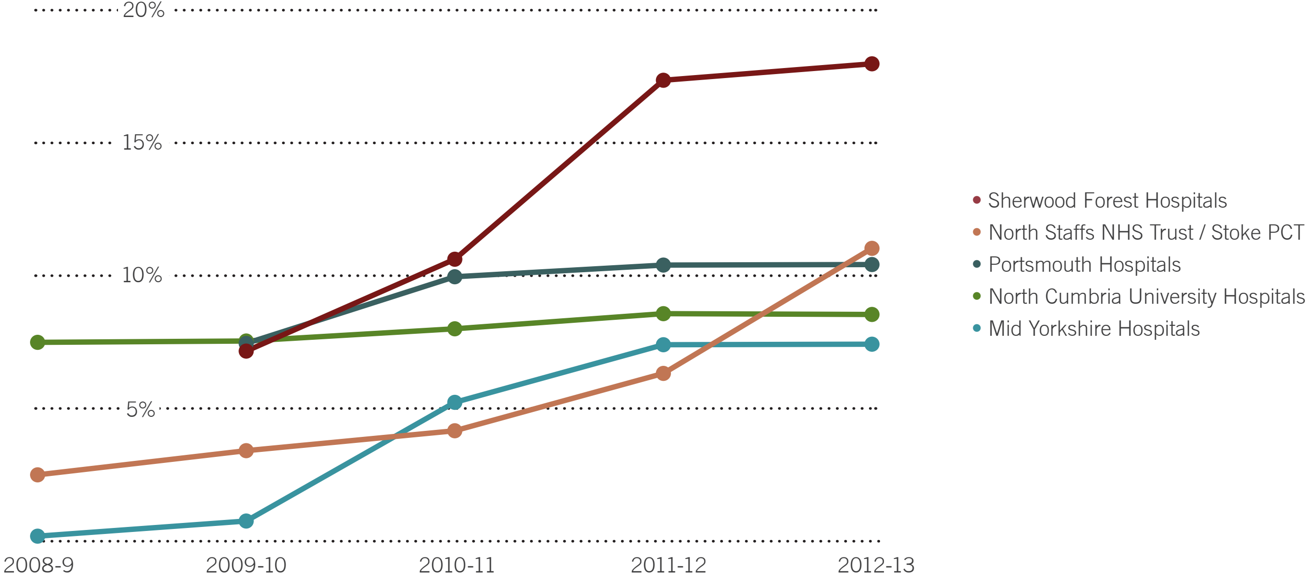


Figure 1: For some indebted trusts PFI payments have been a rising percentage of their overall revenue

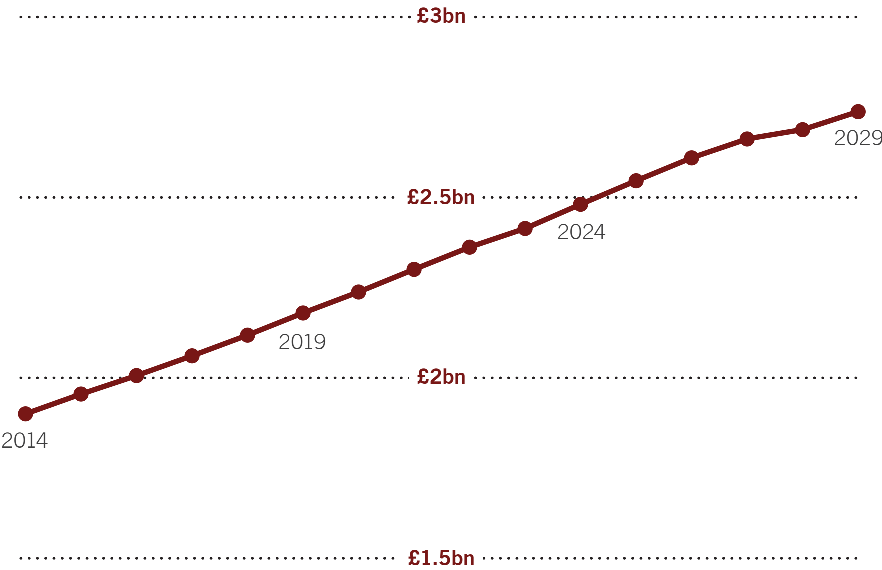


Figure 2: Total annual PFI payments across the NHS will rise for the next 15 years

Figure 3: IndebtedTrusts with the highest PFI payments as a percentage of their operating income 2012-13

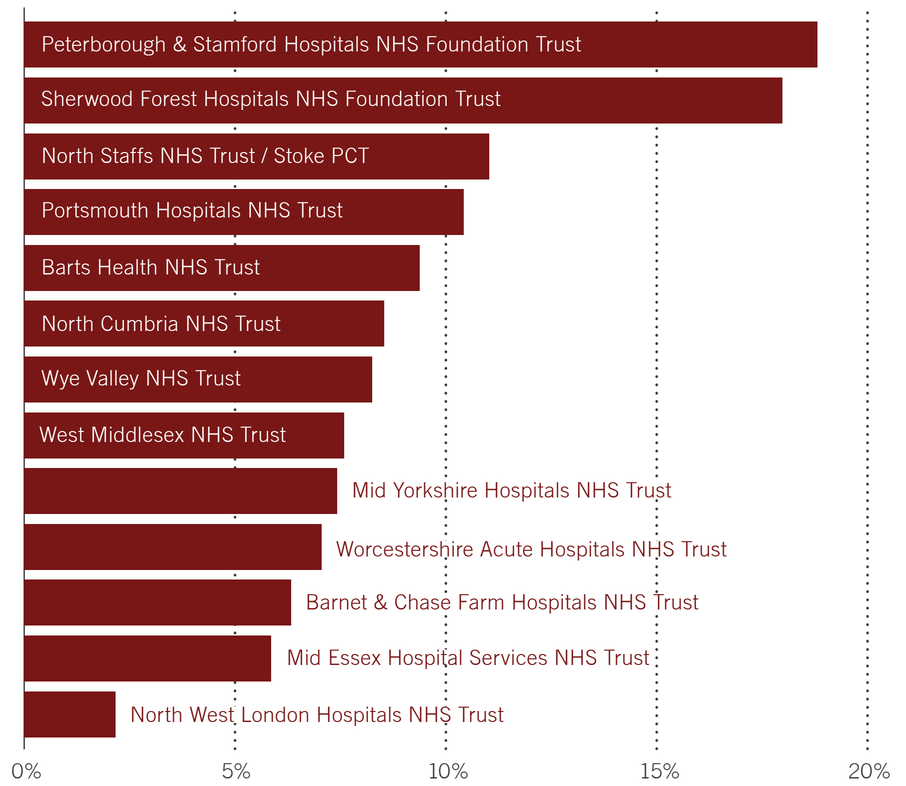
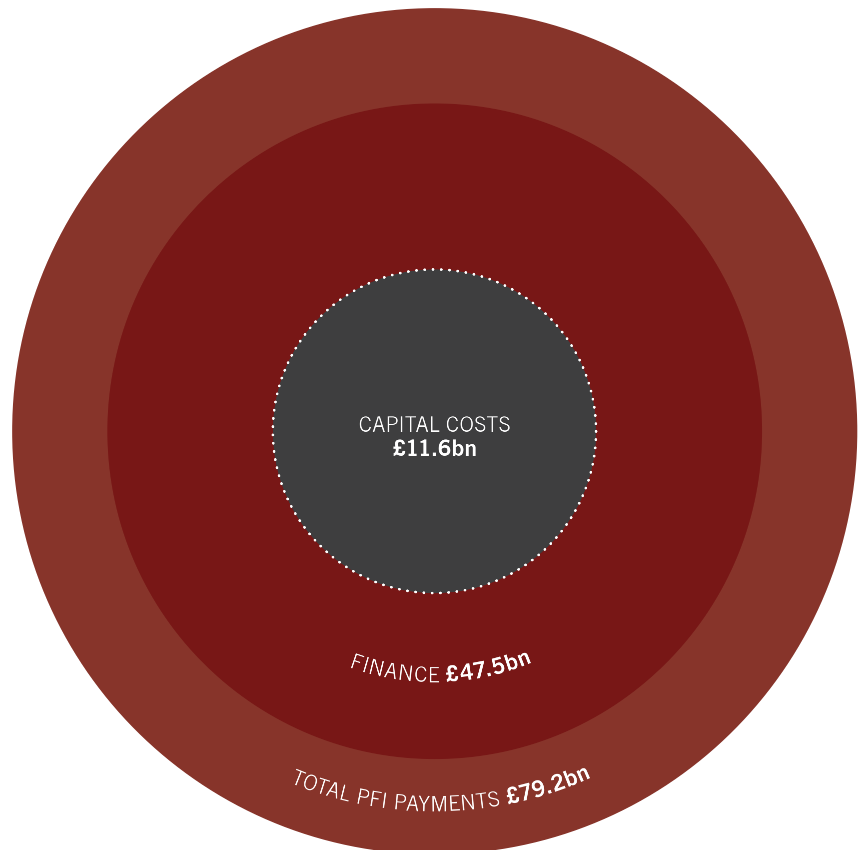


Figure 4: The original capital costs of all the NHS PFI projects and the estimated total payments over the lifetime of the deals



Background

In 1992 John Major's Government introduced the Private Finance Initiative (PFI), a form of Public Private Partnership (PPP), and it has been used ever since by successive governments, both Labour and Conservative, as a means to fund large capital projects. PFI has been the major form of procurement for large NHS projects; by June 2013 209 PFI projects under the auspices of the Department of Health were operational.[1] The majority of these projects are hospitals, with at least 101 hospitals built between 1997 and 2008, or under construction, privately financed through PFI .

A PFI contract is a long-term agreement between the public sector and private sector lasting from 30 to 60 years. Under PFI a consortium of investors, usually investment banks, construction contractors and service contractors, raise finance in order to build new infrastructure. This consortium then designs, builds and operates the facilities for the public authority. The contract is between the public authority and what is termed a 'special purpose vehicle' or SPV. The SPV is a shell company set up by the consortium of investors and has no assets of its own. The finance this company needs is of two types: senior debt, usually lending from a bank, which is low-risk because it is guaranteed by the government; and equity and subordinate debt that comes from a range of investors and is not legally guaranteed and therefore carries a higher risk of non-payment. In general, 90% of the finance for PFI schemes is low risk senior debt and 10% is higher-risk equity. When the construction work is complete and the facility is up and running the public authority (in the case of a hospital – the hospital trust) pays the SPV an annual fee, known as a unitary payment. The unitary payment consists of two parts:

An availability fee – which covers interest and principal payments on the PFI debt and an accumulation of cash reserves to meet life-cycle costs (e.g., maintenance and upgrade costs).

A service charge – which covers facilities management (e.g., cleaning, IT, security etc. often called soft services). Any unspent cash reserves built up are the property of the shareholders in the SPV.

Figure 6: Why is PFI so popular with governments? Under the current accounting arrangements the government excludes the cost of PFI/PPP from national accounts, giving its departments a way of borrowing that doesn't increase the national debt. But of course the debt still exists.

Source: Office for Budget Responsibility, July 2013

The problems of PFI

The high cost of private finance

The cost of borrowing private finance is almost always much higher than the cost of public borrowing. It has been calculated that annual debt repayments to PFI consortiums are between 1.49 and 2.04 times higher than the amount that would have been charged to the UK government if it borrowed directly for the construction projects.[2] In July 2011, the Commons Treasury Committee noted that "the use of PFI has the effect of increasing the cost of finance for public investments relative to what would be available to the government if it borrowed on its own account [...] financing costs of PFI are typically 3-4% over that of government debt."[3] It has been noted that funding a hospital through a PFI contract is akin to a "one hospital for the price of two policy."[4]

The high rate of profit

The rate of profit achieved for the private investors in PFI projects has been found to be excessive – considerably higher than conventional levels of profit for equivalent projects. This was noted by the National Audit Office in 2012 "the public sector may often be paying more than is necessary for using equity investment." Profit from PFI projects can be made in more than one way:

- by the initial investors from the index-linking to inflation of the unitary charge (annual PFI fee paid by the hospital).
- through refinancing by the investors and paying a lower rate of interest on the debt;
- and, from selling the equity of the PFI company.

Profit from the Unitary Charge

The PFI contracts are set up with the unitary charge index-linked to inflation or some fraction of inflation so that over time the amount paid each year increases. However, as the debt is paid off so debt charges fall over time as the payment of interest each year falls. The difference between that increasing element of the unitary charge which covers financing costs and profit, and the declining cost of servicing debt, is available to take as a large profit. One example that has been cited is of a hospital project in England with a capital cost of just under £70 million. To finance the building the consortium borrowed over £60 million from banks, at an interest rate of just over 6% (the senior debt), and provided almost £10 million in subordinate debt for the project, for which the consortium will receive repayment at an interest rate of 15%. The consortium also put in an equity stake of £1,000. The senior debt is paid off quickly and therefore senior debt charges fall rapidly. But the whole unitary charge is indexed-linked for thirty years at 3% per year, therefore, the projected returns to the consortium are that a £1,000 equity input could earn dividends totalling more than £50 million. The consortium's own financial projections indicate that on a total investment of £10 million, the consortium is expecting to get a cash return of more than £90 million.[6] In 2013 other researchers calculated that sponsors of a sample of UK PFI deals had returns of almost 10% above the market rate.[7]

Profit from refinancing

Profitability for investors increases still further when the process of refinancing is considered. After the facilities are up and running the original investors can then use refinancing to reduce the interest they pay. Now the building is complete the period of high-risk is over and the consortium of investors can swap borrowing at high interest rates to lower interest rate borrowing. Under the PFI contracts the NHS trust must receive a share of any profits if refinancing takes place, however this can be small in comparison to the profit taken by the consortium. A good example is the Norfolk & Norwich University Hospital (NNUH) project, where Octagon Healthcare refinanced the project moving from higher-interest bank financing to lower-interest bond financing. The immediate cash gain to Octagon's investors was £95 million and the NNUH received £34 million in the form of reduced rent over the lifetime of the project. Octagon's windfall profit of £95 million represented an annual rate of return on £1.47 million of share capital (in 2003 prices) of more than 120%; this did not take into account net profits after tax of £3.6 million in 2001 and £1.6 million in 2002.[8]

Profit from the secondary market

An SPV is a company owned by shareholders and as such its equity can be traded. Once the facility is built and functioning there are no restrictions on the sale of equity in the SPV. However, unlike refinancing the public sector does not receive a share of any profit. Since the late 1990s a secondary market has grown in the sale of equity in the SPVs and it is now clear that large profits can be made through such trading. For example, Carillion built the first PFI hospital, the Darent Valley Hospital in Kent, which opened in 2000 with 75 fewer beds than the hospital it replaced. Carillion has since sold its equity stake in the hospital to its consortium partner, Barclays UK Infrastructure Fund, for £5.2 million. Carillion made a profit of £16.4 million on an original investment of £4.1 million.[6] The European Services Strategy Unit (ESSU), a database run by Dexter Whitfield, Adjunct Associate Professor, Australian Institute for Social Research at the University of Adelaide, has tracked the ownership of all PFI projects in the UK. According to the ESSU data, the average annual return on the sale of equity in UK PFI project companies was 29% between 1998 and 2012. PFI equity was sold an average of six years after the financial close of the

project. Twelve PFI projects had an annual rate of return of over 100% and another 25 had an annual rate of return of between 50%-100%. Whitfield describes the profits as "excessive", and noted that "It's a wealth machine. It's not necessarily printing money, but it's virtually that, given the scale of these profits."[9] The scale of the profits are indicative of just how bad the original deals were for the pubic sector in the long-term.

Lack of transparency

The trade in equity in PFI companies is not tracked by the Treasury as it regards the sale of PFI equity as a transaction between private companies in which the government has no involvement. At the moment it is extremely difficult to track this market as freedom of information provisions do not apply to private companies. Although the Treasury does produce data each year on PFI projects that lists ownership, according to Whitfield, the information is hopelessly out-of-date and does not give the correct ownership for many PFI projects. A shocking example, cited by Whitfield, is that of Calderdale Royal Hospital in Halifax; from 2002-2010 equity in the PFI company was traded nine times involving companies based in France, Scotland, The Netherlands, the UK and Australia. None of these deals had been recorded by the Treasury.[9] The data in the ESSU database compiled by Whitfield, is obtained from a wide variety of sources, including Stock Exchange Regulatory News Service and Company Notices and Press Releases, Company Interim and Annual Reports & Accounts; and UK Companies Houses filings.

Lack of public accountability

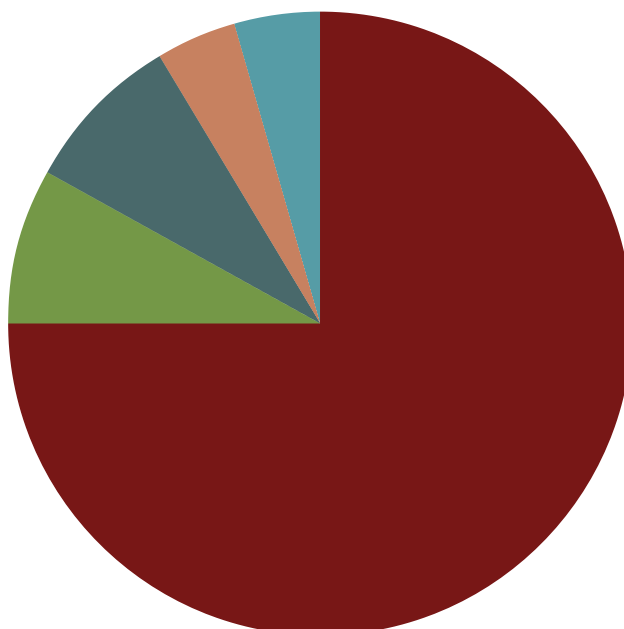
Related to the transparency situation is the lack of public control and accountability. When the PFI projects are set up there is scrutiny of the private companies involved to ensure they are financially robust and are competent, however once the PFI company enters the secondary market there is no control over who buys the equity. The PFI contract could theoretically be owned by any company anywhere in the world. Another facet of the secondary market is the bundling of PFI companies together to enable investors to refinance several projects in groups to squeeze further financial benefits from these assets. It has been noted that this is a concern because those owning the PFI debt are so distant from the actual business that they cannot form a true assessment of the actual risks involved and be an effective role in scrutinising the management of the project.[10]

Tax avoidance

As the trade in PFI equity has increased more and more equity has been sold to companies registered offshore that do not pay tax on any profits. In 2012, it was calculated that 91 shareholder companies investing in UK PFI projects are domiciled in tax havens, mostly Guernsey, Jersey and Luxembourg, and not liable to capital gains tax.[11] Offshore infrastructure funds now account for over 75.0% of PFI equity transactions. They have grown rapidly, building portfolios of public assets with equity in 315 UK PFI projects. Five funds alone have 50%-100% equity ownership of 115 projects. It is reckoned that tax avoidance by infrastructure funds results in a significant annual loss of tax revenue.[11] There is a potential for further loss of tax if the SPV owners engage in transfer pricing, this is when profits generated in the UK are actually booked as occurring in low tax jurisdictions elsewhere. This is likely to be happening as it occurs widely in multinational business, for example Amazon and Google.

Figure 6: Who invests in PFI Equity? Shares in a private company that is set up to run a PFI project are sold in the equity market, often many times.

- Offshore infrastructure fund **75%**
- Other infrastructure fund **8.3%**
- Pension fund **8.3%**
- Construction company, bank or pension fund **4.2%**
- Other financial institution **4.2%**



Source: European Services Strategy Unit

What has been done about PFI so far?

The first major changes to PFI took place in 2009, when the government chose not to renegotiate the deals, but instead opted to create a new fund to provide government loans to projects that did not have sufficient funds from banks due to the worldwide recession. However, eventually, the criticisms of PFI and problems with debt, in particular in the NHS, led to two enquiries, one in July 2011 by the Commons Treasury Committee and one in September 2011 by the Commons Public Accounts Committee. Both enquiries were sharply critical of PFI, highlighting the high cost of credit, lack of thorough evaluation of value-for-money and the complexity of such long contracts that reduced the flexibility needed for public services.[3,12] For example, the Commons Treasury Committee concluded that the financing costs of PFI are usually 3-4% over that of Government debt.[3] Furthermore, the tax revenue from the PFI schemes that the Government assumed would be forthcoming has not appeared as many of the large PFI investment funds are registered offshore. In September 2011 the then secretary of State for Health Andrew Lansley reported that 22 trusts, totalling at least 60 hospitals, were at risk in financial terms due to PFI debts.[13]

PF2

As a result of the mounting problems with PFI debts and the criticisms from the enquiries in 2011, in December 2012, as part of the Autumn Statement, Chancellor George Osborne announced changes to PFI and a relaunching as PF2 (Private Finance 2). The changes are supposed to address the numerous criticisms from the Treasury and Public Accounts Committee reports. The changes include the possibility of direct public investment of up to 49% in projects, although the likely level will be around 20%, and the appointment of a public director to the boards of the PFI companies. Furthermore, there will be an 18 month limit on project negotiations, publishing of annual accounts and the removal of requirements for soft services from the contracts (these include such things as cleaning, security and IT). Despite these changes the schemes will still be funded 80% by debt and there have been no penalties put in place for investors who sell their PFI shares early and generate vast profits.[14,15] Indeed, it has been noted that there will be increased financial complexity of project finance in PF2, with bond finance set to become more common, together with more pension fund, insurance company and other financial institution investment. These developments will make political influence or even control of the planning and procurement process more remote and difficult.[16]

Although PF2 may have addressed a few concerns about the schemes, it has done nothing to address the problems of the PFI schemes already under way, and many Trusts continue to be saddled with schemes that are sucking them dry financially and will do so for the next 25 to 30 years. Furthermore, the changes do not address the lack of transparency with regard to ownership and profits and the problem of the loss of tax revenue through the use of offshore arrangements by PFI investors.[14]

> **“PF2 is essentially a rebranding of PFI. It does nothing to address profiteering from equity sales in PFI.**
> Dexter Whitfield, author of The PPP Wealth Machine

Summary data reported by the Treasury in December 2013 shows that as of March 2013 725 PFI projects were ongoing, with a total capital value of £54.2 billion. Annual payments (also known as PFI unitary charge payments) are expected to total £9.9 billion in 2013-14 and £10.2 billion in 2014-15. According to the Treasury data, 118 PFI projects were operational under the auspices of the Department of Health which amounts to £11.8 billion in capital expenditure, however over the lifetime of the PFI the public sector will have paid £81.5 billion for these projects. This does not include those projects that are in procurement, reported to be 21 in March 2013.

Attempts to produce savings to date

There have been attempts to save money in the PFI contracts. In July 2011, the Treasury asked all Whitehall departments to examine their operational PFI contracts and to encourage the authorities they sponsor to do the same. The Treasury issued detailed guidance to help authorities identify potential savings. The three main areas targeted for achieving savings were: effective management of contracts, for example by reducing wasteful energy consumption, or making sure that the public authority takes a share of cost reductions (e.g. lower insurance premiums); making efficient use of space, for example by subletting building space; and, reviewing soft service requirements, to ensure the public authority does not buy more than it needs. However, by August 2012 seven hospitals were reported to be at risk of insolvency as a result of PFI debts and had to be given £1.5 billion in emergency funds by the Department of Health. The government sent in lawyers and auditors to the struggling trusts to help the trusts find savings and renegotiate contracts. Ministers had found that hospitals were often not getting a fair share of savings that PFI deals make on energy and insurance costs, sometimes hospitals ended up paying for things they did not need and were being charged too high a price for essential services.[17]

The efforts by the Treasury have produced very little in the way of savings. In November 2013 the National Audit Office produced a report assessing the savings that had been achieved by the government's approach to PFI across 13 government departments. The NAO reported that the savings of £1.6 billion reported to the Treasury (both signed and those in the pipeline) derived from just 118 of the 684 operational PFI contracts. There have been no savings made on the remaining 566 operational contracts that have a total remaining unitary charge of £151 billion. The Department of Health performed particularly badly reporting a total saving of just £61 million although it has over 209 operational contracts with a total of £69.4 billion unitary charge remaining, according to the NAO. This £61 million in savings is just 0.09% of the total unitary charge remaining – a drop in the ocean.[1]

According to the NAO, the reasons so few savings have been achieved are lack of expertise and skills in negotiating and a lack of resources to actively manage contracts. The NAO mentions the possibility of refinancing to save money and renegotiating index-linking of the unitary charge, but few public bodies appear to have opted for this approach. The most successful public body in terms of savings has been the Department of Transport, within which Transport for London has bought services in house and bought its way out of several PFI contracts.

Time for a different approach

With the government achieving only minimal savings and so many NHS trusts in dire financial circumstances, it is time to look at other measures to save money in the long-term and recoup a proportion of the excessive profits made by the private companies involved. The options under discussion include the following:

- Buy out of the PFI contract either through the use of reserves or through borrowing from a different, much cheaper, source;
- Renegotiating the PFI contracts to reduce the annual payments either to be closer to that which would have been paid if public money had been used or at least to some 'fairer' level. Whether such negotiations should cover retrospective changes to the deals or not should be considered;
- A tax on the profits made by companies that sell their PFI shareholding;
- Closure of the loophole that allows companies not domiciled in the UK to hold sharesholdings in PFI contracts leading to increased tax payment;
- For a trust to just stop paying.

Buying out of a deal

At first glance buying out of a deal might seem a possible solution for many trusts. By paying back the debt early the hospital is then owned by the trust and it no longer has to pay punitive charges each year. This could be achieved in two ways: either through the trust's reserve or by borrowing from a much cheaper source. The potential to buy out a deal depends on:

- how big the PFI debt is;
- the availability of cheaper sources of borrowing;
- and, the level of compensation payable if the PFI deals are terminated early.

PFI deals vary in size considerably, from around £15 million to over £400 million, and this will be a major factor in whether buying out of the deal is feasible and what route would be taken. There is a precedent for this approach. In February 2011, Esk and Wear Valleys Mental Health Foundation Trust paid off its PFI contract for the re-building of West Park Hospital in Darlington. The 30 year contract meant the Foundation Trust would eventually have paid £32.15 million for the hospital; by buying out of the deal the Trust paid just £18 million to release itself from the contract. The original capital value of the project, which began in April 2004, was £16 million and the Trust paid all senior and junior debt plus legal fees. The contract was with the Norwich Union Public Private Partnership Fund, now known as Aviva. Buying its way out of the PFI contract saved the trust £2 million a year (£1.4 million in interest and £600,000 in maintenance and paying back the principal debt) or around £14 million over the lifetime of the contract.[18,19]

There are also examples of PFI buy-outs in other areas, including the buy-out of a PFI deal for 25 care homes by Southwark Council in April 2013. Southwark Council agreed the original deal with Anchor in 2000, under which the company rebuilt and refurbished four care homes in the area. Anchor agreed to allow the council to complete the repayments early, which will save the council around £930,000 in fees. Anchor provided care services in the homes and will continue to do so, even though the contract has been terminated.[20] The Esk and Wear Valleys buy-out was only possible as the foundation trust had built up a surplus of £41.6 million according to its 2009-10 accounts and the PFI contract was relatively small. Similar small contracts do exist, with data from the Treasury showing that, as of March 2013, 24 NHS trusts in England had PFI schemes with capital values of £25 million or less. However, for cash-strapped trusts trying to save money, the accumulation of such reserve capital is unlikely to meet the level even to pay off a small PFI contract.

For many NHS trusts accumulating such reserves in the current financial climate is impossible. Another option is to borrow from another source. In August 2012 Northumbria Healthcare reported that it had been given in-principle approval from Monitor to buy out two PFI schemes using a £120 million loan from the local authority. The local authority can borrow at much lower rates and so charge the NHS trust a much lower unitary charge. The trust estimated that it will save around £4.7 million per year on the combined cost of its two PFI schemes, which each have more than eighteen years left to run, according to Treasury data.

What about a government buyout?

Within the buy-out option is the possibility of a government-backed buy-out of all the PFI schemes, effectively a nationalisation. This option has been proposed by The Green Party.[25] The options for such are scheme, include:

- the trusts borrowing money from the government at a low rate of interest and the trusts buying their way out of the PFI deals individually;
- or a collective approach with the government negotiating the buying-out all PFI schemes.

The advantage of the second approach is that the government would have more power to negotiate with investors than individual trusts. Funding for such a large buy-out could come from the issuing of Growth Bonds. These would work by allowing individuals, banks, building societies and investment funds to purchase special funds from the government. This is a very common approach in the US, but usually to fund a scheme from its outset.

The nationalization of all PFI schemes is also an option suggested by the union Unison. In 2009 a Unison study noted that "the next logical step is to reform existing schemes, first by removing all soft services (such as cleaning and catering in hospitals) from contracts, and ultimately by bringing all PFI contracts under public ownership and control."[26]

A major consideration for any Trust wanting to buy-out a PFI contract is compensation payments to the investors. As has already been noted, the profit that can be made on PFI schemes means that investors are reluctant to let them go. Generally, the contracts have a compensation payment included for investors, should a trust ever be in the position to pay off the debt. During the refinancing of the Norfolk and Norwich PFI deal it was established that the provider, Octagon would need to be paid £300 million if the project were terminated early.[8] Although there is a great amount of confidentiality surrounding many of the contracts, the treasury does supply guidance on how compensation for private providers should be calculated in the event of the early termination of a PFI contract. Assuming that all the relevant figures are available then it is possible to use this to estimate the buy out costs for a proportion of PFI contracts. This would be an estimate, but using the treasury guidance would make these calculations a valid starting point for debate. The limitation to this approach is that older PFI contracts may vary and involve different compensation costs.

Buying out of a contract by using a surplus generated by a trust is most likely to be confined to small PFI deals. However, David Bennett the chief executive of Monitor has suggested that it may be an option for debt-ridden Peterborough and Stamford hospitals Trust. The PFI deal at this trust, begun in 2007, has a capital value of £336 million and lasts 31 years.[24]

There are two substantive objections to the principle of buying out of PFI deals. Firstly, by paying off these deals further large sums of public money will be taken away from patients to give to private investors. Secondly, many may consider it wrong to further compensate investors when they have already been handsomely rewarded, particularly when pay-offs would be large and the tax paid on them minimal. This could potentially be viewed as rewarding these private investors for their ability to strike an ‘unfair’ deal.

Renegotiating interest payments

The possibility for renegotiating the PFI contracts of projects that are now up and running and therefore at the low-risk stage has been suggested by several sources. In 2010, management consultants McKinsey and Company noted that a reduction of 0.02%-0.03% in interest charges paid to contractors by NHS hospitals could save £200 million a year.[27] Professor John Appleby, chief economist at the King’s Fund think-tank, believes renegotiation of the deals should be tried[28] as does Dr Lucy Reynolds, research fellow at the Faculty of Public Health and Policy at the London School of Hygiene & Tropical Medicine. However, Appleby suggests that the NHS is not in a strong position because lenders feel confident that the treasury will bail out trusts that get into difficulty. In contrast, Reynolds believes the NHS trusts are in a strong position to renegotiate their PFI contracts.

The strong negotiating position is based on the tide of public opinion that could be harnessed based on the growing realisation that the original deals were unfair, with excessive profits being made from the deals but not much tax paid due to the use of offshore companies. From a public relations perspective, it could be difficult for the investors, several of which are banks that the government has already bailed out, to deny a struggling NHS trust a renegotiation of a contract to produce a ‘fair’ payment. If the investors will not renegotiate they are effectively saying they wish things to be ‘unfair’ and to continue to take excessive amounts of money from the NHS.

However, although renegotiation of the PFI deals does at first appear to be a good option for reducing debt, there are problems due to the complexity of these arrangements. The annual unitary charge is composed of a payment for services (approx. 40%) and the availability fee which covers payment of the debt and accumulation of cash reserves (approx. 60%). These two components would have to be negotiated separately. Renegotiating the fee for services could be straightforward, but renegotiating the availability fee could be very complicated due to the presence of the secondary market in PFI equity. Many of the original PFI companies are now owned by a network of investors, many of them based outside of the UK. Negotiations would have to take place with the owners of the senior debt and with owners of the equity in the PFI companies. Each layer of investor would have to be dealt with. The banks with a UK presence, such as Barclays and HSBC, may be susceptible to public pressure but the UK PFI assets may no longer be controlled by companies that have any public presence in the UK and so are far less susceptible to negative publicity.

Control of the investment market

There are two approaches that could be considered to control the PFI investment market and by doing so gain increased tax revenue: (1) a tax on the profit made from the sale of equity or at least a requirement to share this profit with the public sector; and/or (2) the introduction of regulations to ban the sale of PFI equity to companies based offshore thus forcing the companies to pay tax on profits from equity sales.

The rise of PFI in the UK and similar schemes in other countries has spawned a market in trading in PFI equity. Although public sector consent and profit sharing is required when PFI projects are refinanced, there are no such requirements when the equity of PFI companies is sold. The change in the equity ownership of the project is considered by the Treasury to be part of the normal takeover or merger of companies and is different from refinancing projects. At the moment it is extremely difficult to track this market as freedom of information provisions do not apply to private companies. Data from the ESSU compiled by Dexter Whitfield comes from a variety of sources and represents the most comprehensive database on the ownership of PFI companies. The ESSU has come up with startling data about the market in sale of PFI equity, including the large proportion of companies that are registered in offshore tax havens and the number of times equity in PFI companies is sold.[11]

The changes in PF2 do not address the fundamental problems of disclosure of the trading in the secondary market, according to Whitfield.[16] For any tax or profit share requirement to be able to be put in place the problem of transparency will have to be dealt with first. Conservative MP, Jesse Norman, has argued for some time that trading in PFI assets is not a purely private matter, but that there is a public interest in PFI and “there should therefore be mandatory transparency to government on sales of PFI equity and debt as to amount, duration and beneficial counterpart.”[29] Whitfield noted to the Treasury enquiry in 2011 that “contractual terms and/or legislation should require profit sharing with the public sector and be accompanied by improved governance, rigorous monitoring and radical changes to disclosure requirements.”[3] Norman has also proposed that “consideration should be given as to whether the government should have a right to block secondary market sale,” and he has pressed for a rebate from the companies that have made excessive profits trading in PFI equity of between £500 million and £1 billion.[27] In some respects the lack of payment of tax on profits and equity sales could be solved if the sale of PFI equity to companies based outside the UK were put in place.

Just not pay

There are some advocates of just not paying, i.e., for hospital trusts to refuse to pay the availability charge. George Monbiot has written that the PFI debt can be classified as ‘odious’ debt a legal term usually applied to the debts of dictators in the developing world. It applies to debt incurred without the consent of the people and against the national interest. For example, in 2008 Ecuador refused to pay debts which, it argued, had been illegitimately acquired by previous governments. Monbiot believes that this concept applies to at least some of the PFI liabilities.[30] Taking this approach to debt repayment has certain consequences, however, with Lucy Reynolds, noting that just not paying is an option that would “risk disastrous consequences or countermeasures under the contracts leading to hospital site ownership loss and thus immediate closure and redevelopment/ full privatisation.” However, a refusal to pay en masse might prompt the investors to take offers of renegotiation seriously.

Table 2: Summary of the options that have been suggested as ways to address the poor value of PFI

OPTION	HOW?	PROBLEMS	USABILITY
RENEGOTIATING to a fair value	Needs a stimulus to bring parties to the negotiating table, e.g. a strong response to a public consultation or campaign and a firm commitment from political parties	The complexity around the ownership of PFI contracts would need to be overcome	Has a good chance of producing substantial savings
BUY OUT (1) by hospital or swapping to an alternative borrower	Works if the hospital has sufficient reserves or can find a cheaper source of borrowing such as a local authority	Current financial pressures would rule this out for most trusts	Possible for some of the smaller schemes
BUY OUT (2) by government	Would need large upfront expenditure but could be part funded from the issuing of special bonds or ring-fenced taxes	There is a moral question as to whether the government should spend yet more public money buying its way out of unfair deals, where large profits have already been made	Relies upon big public expenditure, political will and public agreement
CONTROL OF THE PFI INVESTMENT MARKET	A tax on the sale of equity and/or a ban on the sale of equity to companies based off-shore	The Treasury would need to start collecting accurate information about the secondary PFI market	Possible way to address the excessive profiteering from PFI schemes
JUST DON'T PAY	Hospitals might refuse to pay their annual charge on the grounds that it excessively undermined their ability to provide services	Exposes the hospital to a strong legal response and could involve a loss of access to the hospital	If done together with other hospitals it could bring companies to the negotiating table, but is a high risk strategy, very unlikely to be pursued by NHS trust managers

NB: The above list is clearly not exhaustive but serves to start the debate. All these options assume that more of our politicians begin to support the idea of taking proper action on PFI not just agree with its failings.

Conclusion

The Private Finance Initiative has been widely acknowledged as a mistake and yet little has been done to rectify it. The cost to our society is huge. Not only in monetary terms but also by way of the treatment and care that has been forgone or delayed because public funds have been diverted from patient care. Over the coming years the PFI burden will increase and coincide with a wider funding crisis for the NHS.

The government will have its own reasons for not taking more action. Powerful financial interests will resist it. The possibility of adding to the national debt will not be attractive. However there are workable solutions and the gains from these far outweigh any of the perceived problems.

We hope that this report will help to raise awareness about some of the choices around PFI and the cost of doing little about it.. However we cannot also escape the reality that PFI operates within the context of a market-based NHS with growing private sector influence. This must also be addressed to ultimately secure the future of our NHS.

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