

# The return of PFI – will the NHS pay a higher price for new hospitals?



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# Contents

.....	
<b>Executive summary</b>	<b>4</b>
.....	
<b>Introduction</b>	<b>6</b>
.....	
<b>How do large PFI hospital schemes impact on the finances of NHS Trusts and their ability to deliver sustainable healthcare services to local communities?</b>	<b>7</b>
.....	
<b>Why would an NHS Trust agree to a PFI deal if the charges are so high and are likely to be unaffordable?</b>	<b>9</b>
.....	
<b>Is PF2 likely to make private finance deals more affordable to NHS Trusts?</b>	<b>11</b>
.....	
<b>Do the coalition government’s reforms remove the perverse incentives for NHS Trusts to enter into private finance contracts which are unaffordable?</b>	<b>15</b>
.....	
<b>Conclusion</b>	<b>17</b>
.....	
<b>References</b>	<b>18</b>
.....	

## Executive summary

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On 12 July 2012 the South London Healthcare NHS Trust became the first NHS organisation to be placed into administration, having recorded a cumulative deficit of £154.2 million on a turnover of £440 million in 2011/12. Although a range of factors contributed to the Trust's financial problems, the high proportion of its income allocated to two large Private Finance Initiative (PFI) contracts – both of them approved in 1996 - was an important contributing factor.

When a hospital is built under the PFI, a private sector consortium raises funds to build the hospital, which it then maintains over a period of 30-60 years. Over this period, the Trust is required to pay a fee to the consortium to make the hospital available for use. All NHS Trusts with large PFI hospitals bear a higher cost of capital than other Trusts. Additional funds from the government to subsidise such payments do not appear to have addressed this problem, so that Trusts with PFI charges are the most likely to incur deficits, often resulting in less money being available for patient care, while private sector consortiums have often made excess profits from PFI contracts.

Despite criticising the use of the PFI while in Opposition, in office the Coalition has continued to use private finance to build NHS hospitals and NHS trusts have continued to sign up to costly PFI contracts. The Coalition has, however, reformed the PFI with the intention of addressing some of the problems of high cost and affordability, rebranding the initiative as PF2.

This report looks at the impact of the Private Finance Initiative on the NHS and at the coalition's new 'PF2' initiative. It asks the following questions:

- How do large PFI hospital schemes impact on the finances of NHS Trusts and their ability to deliver sustainable healthcare services to local communities?
- Why would an NHS Trust agree to a PFI deal if the charges are so high and are likely to be unaffordable?
- Is PF2 likely to make private finance deals more affordable to NHS Trusts?
- Do the coalition government's reforms remove the perverse incentives for NHS Trusts to enter into private finance contracts which are unaffordable?

The report finds that:

- Around 2% of the NHS budget each year is devoted to making annual payments to private sector consortiums for hospitals and other facilities built using private finance.
- Some NHS Trusts are spending significant proportions of their annual income to pay for a PFI hospital, a burden not adequately offset by additional payments from central government. As a result, Trusts with PFI contracts are more likely to run into financial difficulties and have less to spend on staffing and equipment, impacting negatively on patient care.

- Profits in PFI deals exceed the normal rate of return expected for similar types of investments, with investors in some PFI schemes making between 40-70% in annual returns.
- While NHS officials have long known that PFI contracts may be unaffordable they have signed up to the contracts because there is no other way of getting new hospital facilities built – government policy dictates that private finance is the ‘only game in town’, partly because budgeting rules have meant that PFI investments are not counted as part of public spending or the national debt.
- The Coalition’s ‘PF2’ reforms, which require projects to be funded at an even higher cost of capital, are likely to make it more rather than less expensive to build hospitals using private finance.
- As ‘PF2’ will still be the ‘only game in town’ for many large-scale projects there remains a high risk that more unaffordable projects will be entered into by NHS Trusts, further impacting on scarce NHS resources.

The report concludes that the Coalition government’s commitment to marketisation and private sector involvement in healthcare, coupled with unprecedented restrictions on capital spending, means that the use of ‘PF2’ in the NHS may be profoundly damaging for the financial sustainability of local health economies and their ability to address health need.

## Introduction

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1. On 12 July 2012 the South London Healthcare NHS Trust became the first NHS organisation to be placed into administration, having recorded a cumulative deficit of £154.2 million on a turnover of £440 million in 2011/12.<sup>1</sup> The following year, the administrator recommended major service cuts in south London to deal with the deficit, including the closure of an accident and emergency unit and maternity services at neighbouring University Hospital Lewisham. The plan was endorsed by Jeremy Hunt, the Secretary of State for Health, but eventually blocked by the High Court.
2. Although a range of factors contributed to the problems at South London, the high proportion of the Trust's income allocated to two large Private Finance Initiative (PFI) contracts was an important contributing factor. Both contracts were among a large programme of PFI projects approved by the Conservative government of John Major in 1996.\* Recent claims by coalition ministers that structural changes introduced in South London, and closures and downgrades forced on many other NHS Trusts around the country, are examples of 'cleaning up Labour's mess' are therefore disingenuous, at best.<sup>2</sup> In addition, the coalition government has itself made extensive use of private finance since coming to power in 2010. New PFI projects include a £242 million PFI project at the Royal Liverpool and a £206 million project at Papworth Hospital Foundation Trust in Cambridgeshire.<sup>3</sup>
3. In December 2012 the coalition introduced a re-branded version of the PFI programme, called Private Finance 2 (PF2)<sup>4</sup>, under which plans for a number of new hospital projects are now being prepared, beginning with a £432 million scheme for Sandwell and West Birmingham Hospitals NHS Trust.<sup>5</sup> In the context of extensive criticism of the PFI model by scholars, parliamentary committees and the media, the PF2 reforms sought to address a number of structural weaknesses in the policy, in particular the high cost of finance and the incentive to use private finance as a means of deferring payment for capital investment.
4. This report seeks to address the following key questions about the PFI and its successor PF2:
  - How do large PFI hospital schemes impact on the finances of NHS Trusts and their ability to deliver sustainable healthcare services to local communities?
  - Why would an NHS Trust agree to a PFI deal if the charges are so high and are likely to be unaffordable?
  - Is PF2 likely to make private finance deals more affordable to NHS Trusts?
  - Do the coalition government's reforms remove the perverse incentives for NHS Trusts to enter into private finance contracts which are unaffordable?

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\* Outline business cases for the two PFI projects were approved by former Conservative health minister and chairman of the House of Commons Health Select Committee, Stephen Dorrell. Dorrell has since described the debts generated by the deals as 'indefensible'. It was also Dorrell who introduced the 1996 NHS (Residual Liabilities) Act, which guaranteed that central government would stand behind Trusts (and ensure all creditors would be paid) in the case of Trust insolvency.

# How do large PFI hospital schemes impact on the finances of NHS Trusts and their ability to deliver sustainable healthcare services to local communities?

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5. Under a PFI contract, a group of investors (a consortium) organises the financing, construction and maintenance of public sector facilities such as hospitals and schools and receives in return a revenue stream from the government, or from a public sector authority, in the form of annual payments. This model has become a prominent way of delivering public facilities in many developed (and some developing) countries. For example, in the European Union between 2004 and 2013 PFI contracts were agreed with a total capital value of €207 billion.<sup>6</sup>
6. For governments, one important advantage of this model is that new or refurbished facilities can be provided without immediately affecting the most widely used measures of capital spending, net borrowing and the stock of national debt. If private finance is used, the impact of capital investment on these measures is deferred for several years, and is thereafter ‘smoothed’ over the period of the contract (often 30 years or more). This is attractive to government decision-makers who face a common problem of maintaining good public facilities in a context in which capital budgets are tightly controlled. This is especially true today. After accounting for depreciation, public capital budgets are 1.4% of GDP in the current financial year, down from 3.4% at the end of the last decade<sup>7</sup> – a reduction in investment without historical precedent.
7. Although the investments associated with PFI projects are ‘off budget’ in the way described, they generate a future liability for the public sector that is in most respects analogous to a sovereign debt commitment: the state commits to paying the annual fees to the private consortium, and this payment has to be made as long as the facilities are available to be used by the public sector. The long-run cost to government of this commitment is substantial. Indeed, research has shown that, in some cases at least, these costs are unaffordable for the individual public sector organisations involved.<sup>8</sup>
8. The total capital value of PFI projects in the English NHS is approximately £15 billion in today’s money.<sup>9</sup> For the delivery of these assets, and their ongoing maintenance, the NHS in England currently spends about £1.9 billion, or 2% of its annual budget, on PFI charges. If we think of ‘affordability’ as a measure of a project’s impact on the ability of the NHS to deliver sustainable healthcare services to the population, the overall cost of PFI projects appears to be affordable. However, affordability problems may still occur because the responsibility for making the annual PFI payments rests with individual NHS

organisations, which bear substantial financial risk in the newly marketised NHS. And it is apparent that some NHS organisations may be left with insufficient financial resources to provide comprehensive healthcare to local communities as a consequence of their requirement to pay these charges.

9. The experience in South London is, in fact, illustrative of a wider trend. All NHS Trusts with large PFI hospitals have a more expensive estate and bear a higher cost of capital than other Trusts. But the fixed-price, treatment-based payment regime used by NHS England to fund NHS hospitals does not provide any additional revenue to cover these costs, so that Trusts with PFI hospitals are left with a shortfall. In order to pay for these higher costs Trusts have, in general, focused on reducing the amount spent on staff and equipment. Hence, the clinical capacity of NHS hospitals funded under PFI has been restricted relative to what would be possible in the absence of these charges.
10. A key question, therefore, is what determines the size of these charges. Inevitably, the charges are set at a level that is sufficient to provide private investors with the annual rate of return (an important measure of profitability) that they require. There is abundant evidence that the rate of return on PFI contracts is extremely high by comparison with the returns available on other types of investments that carry a similar level of risk.
11. Empirical research has shown that the rate of return on PFI deals typically exceeds the opportunity cost of capital estimated using the Capital Asset Pricing Model (CAPM) - a method that is commonly used by firms to determine the minimum acceptable return on their investments.<sup>10</sup> In addition, a number of reports have compared the return on investment expected by PFI consortiums when the contract with the public authority is signed against that which is expected after a few years of the contract's operation. In many cases, the increase in the expected return after contracts are signed has been large.
12. For example, on the Princess Royal University Hospital PFI contract (one of those that has contributed to the financial problems in South London), the expected return increased from 22% at the time contracts were signed to 71% after investors refinanced their loan.<sup>11</sup> Other examples of this effect include the Norwich & Norfolk Health Care NHS Trust's PFI project, on which investors increased their return from 19% to 60%, and Dartford & Gravesham Hospital NHS Trust, on which the return increased from 21% to 56%.<sup>11</sup> Returns to primary investors can also be increased by selling their equity to other investors. So long as the buyer of the equity is willing to accept a lower return on their money than that expected by the seller, this results in a capital gain. It has been shown that investors have attained returns of up to 40% after selling their assets.<sup>12</sup> These returns show that contract prices have been set inefficiently high, and helps to explain why some NHS Trusts are paying such high annual PFI payments.



## Why would an NHS Trust agree to a PFI deal if the charges are so high and are likely to be unaffordable?

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13. The question then arises as to why NHS organisations would agree to pursue investment projects that carry high contract prices, provide investors with a ‘supernormal’ excess return, and are likely to give rise to unaffordable costs once completed. Technical explanations (poor forecasting techniques, inadequate data, honest mistakes, problems in predicting the future, lack of experience among forecasters, poor commercial skills among public sector negotiators) may play a part in the problem but are unlikely to provide a comprehensive explanation.
14. Alternative explanations might be found in psychosocial theories which focus on the complex nature of managerial decision-making within organisations, public and private. In this view, managers are subject to a so-called ‘planning fallacy’.<sup>13</sup> They make important decisions based on myopic optimism rather than on a rational weighting of gains, losses, and probabilities, as might be assumed in simple theories of public administration.
15. Decision-making by local managers is also likely to be affected by their relationship with central government, especially if: (i) there is a strong political steer from central government towards the use of the private sector for the delivery of assets and services; and (ii) the fiscal framework used by governments leaves the PFI route as ‘the only game in town’.
16. In this context, planners within provider organisations may, in their economic and financial appraisals, strategically underestimate the future costs of projects and overestimate the income that will be available to pay for them. In a marketised healthcare system, provider organisations may also pursue large-scale capital investments as a means of increasing their scale, or the size of their claim over the financial resources of the local health economy.\* In this sense, capital investment that is made possible by the off-budget nature of private financing may serve the interests of individual provider organisations, at least over the medium term, but may be undesirable from the perspective of the wider healthcare system or social welfare more generally.

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\* As noted, under the 1996 NHS (Residual Liabilities) Act, payments to PFI consortiums are underwritten by central government. The fact that central government has to pay regardless of whether the associated NHS Trust is still delivering services means that government has a strong incentive to ensure the Trust has sufficient income to do so.

17. The actions of managers at the Peterborough and Stamford Hospitals NHS Foundation Trust, which in 2007 signed a contract for a PFI hospital with a capital value of £301 million, or 142% of the Trust's turnover, provide support for such an interpretation. Ten months after the new PFI facility became operational (and charges began to be levied by the private consortium) the Trust was placed in breach of its authorisation as a Foundation Trust by the financial regulator, Monitor. Despite additional subsidies from other parts of the local health economy, the Trust's income and expenditure deficit in 2011/12 was 22% of its annual turnover.<sup>12</sup> The Trust's deficit for the financial year 2012/13 was £54.3 million.
18. Interviews and a review of board minutes by the National Audit Office showed that the Trust's managers were strongly committed to the project, and were willing to accept 'unrealistic projections of future Trust finances'. The scheme was also evaluated by the Department of Health, which signed off on the plan despite extensive local opposition. Monitor identified a significant probability that the scheme would be unaffordable to the Trust once 'reasonable assumptions' were applied.<sup>14</sup> The regulator, however, lacked the formal powers or influence required to persuade the Trust's board or departmental officials. The scheme was approved by the Secretary of State for Health and ultimately by the Treasury, without Monitor's concerns being resolved to its satisfaction.
19. In this case, technical explanations of policy failure are inadequate, as managers were willing to accept projections of future Trust finances that were objectively unrealistic. The Department of Health took assurance that it was affordable on the basis that annual PFI payments would not exceed 15% of projected Trust income – but this was not projected to be the case until well into the life of the scheme.<sup>12</sup> The failure to acknowledge the risks to affordability thus appears intentional rather than accidental. At central government level, the failures appear to have been driven by a strong political drive towards private sector involvement in public services, and a budgeting regime that allowed the impact of privately-financed projects to be deferred (see paragraphs 35-40).
20. At the local level the commitment to private finance is understandable given the extent of historic underinvestment in the healthcare estate, the absence of alternative financing options and an increasingly marketised environment that provides incentives for organisations to grow in scale and safeguard their income. Unaffordable PFIs are therefore more likely to be commissioned where there is an ideologically-driven push from the centre for privatisation of various forms, and where there is an absence of alternatives, as when the fiscal framework in effect precludes the state from financing needed investments using public funds. There are clearly features of PFI, and the wider institutional setting in which it operates, that have compromised the ability of the NHS to fulfil its social mission to meet population health need. The rest of this report assesses the extent to which the government's move from PFI to PF2 helps to address these issues.

## Is PF2 likely to make private finance deals more affordable to NHS Trusts?

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21. The proposals to reform the PFI and create PF2 came after a 12-month Treasury review of the policy which was, in turn, prompted by a number of political and economic developments. First, a critical report on the coalition government's use of PFI by the House of Commons Treasury Select Committee had contributed to an increase in hostile media attention. This posed particular difficulties for the two parties of the coalition government, both of which had been strongly critical of PFI, describing it as 'discredited', while in opposition.
22. Second, ministers began to acknowledge that the economic case for the PFI had weakened in the wake of the financial crisis, which reduced the availability of private capital while increasing its cost. The higher cost of finance after 2008 meant that to continue borrowing from the private sector in the way that had occurred under earlier PFI deals had become more difficult to justify. As a result, if private finance was to continue to play a role in public infrastructure projects it would be necessary, in political management terms, to be seen to be finding ways of exerting downward pressure on costs.
23. The government remained committed to the use of private capital, arguing in particular that 'elements of PFI have offered benefits' including 'the private sector's project management skills, innovation and risk management expertise, such as, ensuring buildings are delivered to a high quality, on time and budget and that assets are maintained to a high standard throughout their lives'.<sup>15</sup> To continue to enjoy these benefits, however, the cost of capital had to be reduced.
24. To achieve this the government changed the types of investors who would provide capital and the terms on which they would do so, and introduced a new role for the public sector in financing these deals: pension funds and insurance companies, and not commercial banks, are now required to provide most of the debt capital.<sup>16</sup> Such investors are comparatively risk-averse and are ready to accept lower returns in exchange for lower risk. To facilitate the involvement of pension funds and insurance companies in public infrastructure projects, the coalition has therefore deliberately reduced the risk borne by investors.
25. Two elements of the PF2 model are designed to reduce the risk to risk-averse investors and involve them in private finance contracts. First, 'soft' facilities management services (e.g. catering, cleaning and security) are no longer included within the bundle of activities transferred from the hospital to the PFI consortium's control. This reduces risk, as the scope of the project, after the construction works, is reduced to simply maintaining the facility at the standard contractually agreed. For the government, this also serves to reduce the level of political risk, since active trade union opposition to such transfers is no longer likely to be a significant factor in the debate surrounding the use of private finance.

26. Second, and of greater economic salience, is a change in how much of the funding for projects comes from debt (in the form of bank loans or bond finance), and how much comes from risk capital (known as equity) that is provided by the firms that own the private consortium. The ratio of debt to equity is known as ‘gearing’ and this has a significant impact on the cost of annual PFI payments.
27. Under PF2, consortiums which bid to undertake projects are required to structure their bids on the basis of 20-25% equity, and 75-80% debt, rather than the 10% equity and 90% debt that became the norm for PFI projects. The rationale for doing this is that it strengthens the consortium’s ability to absorb risk, and thereby enables more risk-averse investors to become involved.
28. The effect, however, will be to increase the overall cost of capital compared to PFI, and therefore the charges to be paid by the public sector, since a higher proportion of the funding is derived from higher-cost equity than from lower-cost debt. This effect can be seen Table 1. If it is assumed that market rates for equity and debt remain at their current levels,<sup>\*</sup> the intended change in capital structure will increase the annual rate of return to private investors, by about 15%. This means that PF2 deals are likely to be more expensive than the original PFI deals.

**Table 1: Bank-financed PFI structure versus PF2 (current rate)**

PFI				PF2			
	Proportion	Cost	Weighted Cost		Proportion	Cost	Weighted Cost
<b>Equity</b>	10%	15%	1.5%	<b>Equity</b>	25%	15%	3.75%
<b>Debt</b>	90%	6.25%	5.63%	<b>Debt</b>	75%	6.25%	4.69%
<b>Pre-tax Weighted Average Cost of Capital</b>				<b>Pre-tax Weighted Average Cost of Capital</b>			
<b>7.13%</b>				<b>8.44%</b>			

Source: Hellowell, M. (2013), ‘PFI Redux?: Assessing a New Model for Financing Hospitals’, Health Policy, 113(1-2), 77-85.

29. The implication of Table 1 is that the overall return to investors (of all kinds, including debt and equity), denoted here as the Weighted Average Cost of Capital (WACC), will increase as a result of PF2. With a debt/equity ratio of 75/25, the cost of debt would have to fall by more than a quarter, to 4.8%, to generate a lower overall cost of capital than would be the case under an equivalent PFI project. This is a highly unlikely scenario in the current market.
30. The higher cost of capital under PF2 has implications for what the NHS can afford when commissioning a privately-financed hospital. The implication of Table 1 is that the affordability problems experienced with PFI may be

<sup>\*</sup> The analysis assumes a base rate of 3% per annum, a risk premium of 3% per annum (which ratchets up to 3.5% per annum half-way through the contract period), and a return to investors of equity capital of 15%.

replicated or even aggravated with PF2. To counter this effect the Treasury has introduced plans to include some government equity in the capital structure, so that not all of the funds to build and run the hospital will come from the private sector. This will reduce the effective WACC since the public sector will earn a return on its investment (equivalent to that earned by private investors) that is in proportion to its share of the equity.

31. The extent of the reduction in the net cost of capital that this represents will depend on the proportion of equity provided by the public sector. It is intended that this will be no more than 49% of the total equity (so that the consortium will be majority-owned by the private sector) and no less than 25% (so that the public sector has a right under company law to veto board decisions). As Table 2 shows, again assuming current market rates, a public sector equity stake of 25% of total equity reduces the net cost of capital to 7.5%, while a 49% share of total equity reduces the net cost to 6.6%.

**Table 2: Effect of public equity stake on net cost of capital**

	Proportion	Cost	Weighted Cost
Private equity	25%	15%	3.75%
Debt	75%	6.25%	4.69%
<b>Pre-tax WACC (public equity = 0% of total equity)</b>			<b>8.4%</b>
Public equity (25%)	6.25%	15%	-0.94%
<b>Net WACC (public equity = 25% of total equity)</b>			<b>7.5%</b>
Public equity (49%)	12.25%	15%	-1.84%
<b>Net WACC (public equity = 49% of total equity)</b>			<b>6.6%</b>

Source: Hellowell, M. (2013), 'PFI Redux?: Assessing a New Model for Financing Hospitals', Health Policy, 113(1-2), 77-85.

32. Taking a government stake in the equity is therefore proposed as a means of reducing the cost of capital in PF2 deals. However, from an economic perspective, the government overstates the benefits of its equity stake. First, there is an opportunity cost to the investment of this capital equal to the benefits that could accrue to possible alternative uses for it, for example paying off government debt. Second, the investment is subject to risk, and the actual returns to the taxpayer may be lower than is expected at the time of financial close. Third, it is unclear how the government's representatives on a consortium board will balance their duties to the consortium (which the government part-owns) with their duties towards the health needs of the population served by the hospital trust concerned. If the result is that the public interest is any way compromised, this offsets the benefits of the lower (net) cost of capital.

33. Another possibility is that, as a result of the greater proportion of equity in the project, the cost of debt will diminish as debt providers perceive that there is a lower probability of default. This may mean they are able to charge a lower price for their capital. Whether this occurs, however, will depend on the extent to which institutional investors – such as pension funds or insurance companies - choose to enter the market in sufficient numbers to provide debt on a competitive basis. As noted above, in order to offset the higher cost of capital attributable to lower gearing (before making an adjustment for the effect of the public sector equity stake), market entrants will need to undercut the current bank rate by about a quarter, which is a highly unlikely scenario (see Table 1).
34. The most probable outcome from the introduction of PF2, therefore, is that the cost of private sector capital to be paid by the public sector over the period of the contract will increase compared to previous experience with PFI. It is therefore apparent that the move to PF2 will not address – indeed is likely to further aggravate – long-standing concerns that the private finance model generates high rates of return to investors at a cost to the public sector that is, in many cases, unaffordable.

## Do the coalition government's reforms remove the perverse incentives for NHS Trusts to enter into private finance contracts which are unaffordable?

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35. For successive governments, the economic costs and benefits of private finance have been less important than budgetary considerations – in particular whether the schools and hospitals built under PFI appear in the main measures of capital expenditure, net borrowing and the stock of national debt. The advantages that accrue to 'off budget' financing\* have been a major factor for spending departments, the devolved administrations, and the Treasury (which can, in principle, borrow unlimited amounts, although in practice it generally seeks to reduce net borrowing).
36. Ultimately, this advantage arises from certain anomalies in the financial reporting processes which allow authorities that use private finance to defer the recognition of capital investment in budgets and in the national statistics. This encourages managers and officials to take investment decisions which might not be affordable, in the sense of compromising the ability of healthcare organisations to meet population health need.
37. The government claims to have addressed these perverse incentives in two ways. First, through changing the way in which private finance projects are recorded in the national accounts, by adopting international accounting standards. At one level this has meant that, since 2009, a significant proportion of PFI deals that were 'off budget' are now recorded on the balance sheets of the public authorities involved, such as hospitals or local authorities. However, any capital investment which is secured under PF2 will not be counted as public sector capital expenditure, and will not be netted from departmental capital budgets, nor will it contribute to the estimation of net borrowing or the stock of national debt in the same way as projects that are financed using public funds. As long as the risks of privately financed projects are deemed to have been passed to the private sector, the recognition of capital investment in these statistics is deferred. As a result, there is still a strong incentive for spending departments and the Treasury to promote PF2 financing over conventional public alternatives even if the true scale of public liabilities is increased by it.

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\* The common term applied is 'off balance sheet' but this is misleading, for the simple reason that the government does not have a balance sheet, and so it has not been used here.

38. Second, as part of the PF2 reforms, the government intends to introduce a cap on the proportion of future public expenditure that can be used to pay for private finance projects. The government has set the cap at £70 billion over the 5 years from 2015/16 to 2020/21.<sup>17</sup> This will cover the existing stock of PFI contracts, as well as new PF2 contracts signed. In effect, it will mean that taxpayers' annual payments to private finance projects will be capped, albeit at a level that will still allow approximately £1 billion of new PF2-financed investments to be agreed in each year.
39. The aim is to create a hard budget constraint for privately financed contracts that is analogous to that which departments face in relation to conventional public capital spending. This will partially reduce the incentive to pursue PF2 for budgetary reasons at central government level – i.e. there will be a limit to how many private finance deals can be signed each year. But this is unlikely to address the incentive of individual NHS Trusts to proceed with PF2 projects for investments they perceive to be necessary, even where these are known to be expensive, and even perhaps unaffordable. Fundamentally, this latter incentive is due to the fact that private finance is still 'the only game in town' for large-scale investments due to the absence of capital funds in the current fiscal framework.
40. In a context of rapidly falling capital budgets, alongside fixed or falling revenue budgets from which to finance PF2 unitary charges, the potential for unaffordable new private finance contracts to be entered into by NHS organisations thus remains a major threat.



## Conclusion

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41. The main implication of the contractual changes introduced as part of the move from PFI to PF2 is that the cost of private financing, ultimately funded by the government, will *increase* relative to historical experience with PFI. The latter is a programme that has been consistently shown to have provided excess profits to investors. Despite the coalition government's reforms to the PFI, strong fiscal, budgetary and organisational incentives to pursue private finance remain. These incentives are associated with poor investment and financing decisions that have often compromised the financial sustainability of healthcare organisations and their ability to deliver their social objectives.
42. Indeed, these incentives may be enhanced in a policy environment that is characterised by: (i) continued pressure from central government for greater private sector involvement in healthcare, (ii) unprecedented restrictions on the capital budgets available to government departments and individual public sector bodies, and (iii) an increasing degree of marketisation in which there is a strong motive for provider organisations to enhance their market power through large-scale capital investments, however they are financed and at whatever cost. Experience suggests that the consequences of such an incentive framework may be profoundly damaging for the financial sustainability of local health economies and their ability to address health need.

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