Costs and benefits of private finance initiative schemes

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The private finance initiative (PFI) is the biggest building programme in the history of the NHS. It aims to raise the quality of health care facilities by utilising the skills and expertise of companies in the private sector. This article outlines what PFI involves, how it works and the benefits to the NHS in raising the quality of health care facilities.

Private companies have always built NHS hospitals. Once constructed, the hospitals managed their own finances, services and maintenance and the assets were publicly owned (Unison, 2004).

The private finance initiative (PFI) is the most recent building procurement policy, introduced by the Labour government in 1993 (Public Art Online, 2004). The aim is to raise the quality of health care facilities by utilising private sector companies’ skill and expertise – a challenge supported by a number of prominent organisations such as the Department of Health, NHS Estates, the King’s Fund and the NHS Modernisation Agency, in addition to architectural institutions such as the Commission for Architecture and the Built Environment (Public Art Online, 2004; DoH, 1999).

PFI is the biggest building programme in the history of the NHS. It is predicted that, by 2008, £4.2bn of investments will have come from PFI schemes (Public Art Online, 2004). Currently there are 21 complete and operational health care PFI schemes, 12 that have reached financial close and 24 in negotiation. A further 21 schemes are planned for the future. PFI schemes have become increasingly associated with modernising health care facilities.

How does it work?

Under a PFI, a private consortium (sometimes called a special purpose vehicle) is set up to run the project (Ware, 2004; Unison, 2004). The consortium is made up of a number of companies, including builders, architects and specialist facilities management.

PFI schemes generally follow a design, build, finance and operate (DBFO) process (Table 1). This is a useful summary of the private sector’s obligation in relation to the project (Ware, 2004).

Finance

PFI schemes are governed by the same standard process as all NHS investments, set out in the Capital Investment Manual (DoH, 1994). To ensure that the number of PFI schemes progressing through the system is realistic and that they have a good chance of success, major schemes (capital value over £40m, increased from £25m in January 2004) are prioritised by the DoH on the basis of health service need.

The DoH has set out guidance for trusts undertaking a PFI scheme, The Strategic Outline Case: Guidance Regarding 2004 Prioritisation Round (DoH, 2004). The process requires NHS trusts to demonstrate the following:

- The project is service led and centred on patient need;
- The local community and staff members are involved from the outset in developing proposals;
- The proposal meets the needs and objectives set out in the locally agreed health service strategy and also reflects the strategy for the wider area and the main health authorities;
- Both the trust and strategic health authority agree that the scheme would be affordable and deliverable (DoH, 2004).

Once the PFI scheme has been agreed by the trust and strategic health authority, the project can proceed (Fig 1, p36). The Official Journal of the European Union (OJEU) is the designated journal where PFI projects are advertised to identify potential private sector companies, so the NHS trust can get the best financial agreement.

Finance for the PFI scheme is provided by the private consortium. No one company within the consortium is liable for the entire financial risk – instead it is shared among them. Once the building has been constructed, is operational and has met the standard required, the health care provider (NHS trust) pays a charge for using the building over a predetermined time period, usually 25 or 35 years. This strategy has been likened to a mortgage – an agreed sum of money is lent by a bank/building society (the funders) to a borrower (the private consortium) to purchase/build a house (the hospital). This money is then repaid by the borrower to the funder using the money from the annual
TABLE 1. STAGES OF THE PFI ‘DBFO’ PROCESS (DoH, 1999)

<table>
<thead>
<tr>
<th>STAGE</th>
<th>EXPLANATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Design</td>
<td>Based on requirements specified by the NHS</td>
</tr>
<tr>
<td>Build</td>
<td>To deadline and at a fixed cost</td>
</tr>
<tr>
<td>Finance</td>
<td>The capital cost is financed by the annual charge paid by the NHS to use the building(s)</td>
</tr>
<tr>
<td>Operate</td>
<td>Providing facilities and support services</td>
</tr>
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</table>

charge paid by the trust for using the building (mortgage repayment). Furthermore, if agreed, the private consortia may also provide non-clinical services, for example catering or cleaning.

One incentive for NHS hospitals to use the scheme to modernise is that financial risk is carried by the private consortium, reducing the risk for the NHS of procuring new assets and services, such as new facilities. Also, the public sector may not be able to raise the capital required to build and modernise health care facilities.

Any PFI project must demonstrate value for money (DoH, 1999). This is an economic test applied to the ‘whole of life’ cost of the project compared with a public sector equivalent (Ware, 2004). Value for money is achieved by:

- The private consortium assuming the financial risk associated with a new build, for example overrun costs (Unison, 2004; DoH, 1999);
- Financial certainty – the cost is agreed when the trust and consortium sign the agreement;
- Utilising the experience, skill and expertise of the private partners to achieve cost efficiencies that may not otherwise have been achievable.

When demonstrating value for money, the benefits described frequently outweigh the disadvantages of private companies having to borrow money at a higher rate of interest than the public sector.

**Working to financial close**

Prior to the PFI contract being awarded bidders submit fully priced offers based on an invitation from the trust to negotiate (Fig 1, p36). The trust uses ‘output specifications’ to inform the private consortium how it wishes the service to work. These define the nature and level of service required for each department included in the PFI project. It is not for the trust to instruct the consortium how to design the building or departments but to describe how it wishes a building or department to work. The consortium uses its experience and skill to interpret this information to provide a building that is efficient, operational and meets NHS requirements as well as providing the community with a civic landmark.

Once the preferred bidder has been chosen, a further proportion of work related to design and construction is completed prior to both parties signing the contract (financial close). This ensures financial certainty for the trust and funding certainty for the private consortium by reassuring its financiers. This is achieved by agreeing the build cost of a significant proportion of the project. This proportion most commonly includes departments with specialist, high-cost facilities, for example labs or investigation facilities such as imaging, or high-volume facilities like offices and toilets.

**Benefit for the NHS**

As described earlier, one of the benefits to the NHS is the transfer to the private sector of risk associated with modernising health care facilities. This not only includes the build, but also the cost of buying the building, the associated running costs and performance. For example, in the contract it may state the private consortia should replace equipment according to predefined lifecycles (the life of a piece of equipment) and replacement dates. If targets are not met the private consortium would be subject to penalty clauses payable to the trust.

Gaffney et al (1999) commented that health care facilities have previously been subject to substantial underinvestment, which has resulted in a backlog of maintenance. PFI projects have begun to address this issue. The private consortia are not only modernising health care facilities via new builds, but are also responsible for their maintenance, again subject to penalty clauses. The perception is that lack of finance and delayed maintenance are key problems within the current NHS, but whether the PFI scheme is resolving these issues is subject to fierce debate.

In 2002 a survey was undertaken of 26 chief executives each involved in a PFI project that had reached financial close at a value of over £10m. It showed 88 per cent of new facilities were delivered on time and 79 per cent of projects achieved their ‘decant’ programme – the process of moving from the old building to the new. Some 70 per cent of respondents described their relationship with the private sector as ‘average’ or ‘above average’ and
40 per cent ‘good’ or ‘excellent’. A true partnership relationship is complex due to the pressure of delivering the scheme to time and within the financial constraints (Ernst & Young, 2002). The workings of this relationship are frequently debated - can the public sector’s focus on the patient be balanced against commercialism and profit?

PFI gives NHS professionals the opportunity to pursue exciting new career pathways. For example, an NHS project team will consist of financiers, project managers, human resource advisers, capital planning, estates, legal and risk management representatives, and a host of clinical advisers. This experience can be transferred back into the NHS trust or transferred to subsequent PFI projects by professionals moving to other trusts or PFI consortia.

**Concerns about PFI projects**

The financial benefits of PFI projects will be debated for some time to come as the impact of the long-term investment is realised. The scope, configuration and supporting facilities agreed in PFI projects have been described as inflexible (Ernst & Young, 2002), but their impact will only be fully appreciated as they enter into their agreement. It is clear that changes and modifications to the original output specifications prepared by trusts when inviting private companies to submit their bids have potential financial consequences. The impact of this will only truly be understood in the long term. Indeed, prior to financial close the cost of making changes is closely monitored. Changes are limited but their need is recognised (Ernst & Young, 2002). Whether PFI projects will be able to deliver the necessary flexibility to cope with future changes in health care requirements remains to be seen.

**Conclusions**

PFI can be likened to a mortgage allowing the NHS to provide patients with modern, purpose-built facilities that are maintained by a consortium to an agreed standard throughout the lifetime of the agreement. This in turn provides clinical and non-clinical working environments that are focused on patients and staff. In addition, the design incorporates new ways of working that improve efficiency and effectiveness.

The advantage of PFI is that risks previously faced by the NHS are transferred to the private consortia. By ensuring value for money, the development is delivered on time and includes the costs associated with buying and maintaining equipment.

Furthermore, the PFI process is robust, governed by strict guidance that provides financial security by defining the nature and levels of services. Finally, PFI offers new opportunities for partnerships between the public and private sectors, as well as new opportunities for NHS staff.