

## **Table of contents**

### **Introduction**

What is PFI? .....	2
What does the policy involve? .....	3

### **The extra costs of PFI**

Increased “headline” costs of schemes .....	4
Rate of return for private investors .....	5
Margins for PFI consortium partners .....	5
Fewer beds .....	6
Consultancy fees/negotiation costs .....	7
Delays in major projects – and smaller ones .....	7
Staffing levels reduced .....	8
Privatisation of support services .....	8
“Railtrack on the wards” .....	9
Loss of additional income .....	10
Squeeze on clinical staff .....	10
Squeeze on community services .....	10
Poor quality buildings .....	11
Land assets stripped .....	11
Refinancing: another private sector rip-off .....	12

### **“Hidden”, non-financial costs**

Planning distorted .....	13
Accountability weakened .....	14
Potential for corruption .....	15
Voters say “no thanks” to PFI .....	15

### **How does PFI show “value for money”?**

Untested assumptions .....	15
“Only game in town” .....	16
NHS innovation excluded .....	16
“Public Sector Comparator” .....	16
Discounting the future .....	17
“Risk transfer” .....	17
Subsidies – open and covert .....	17

### **Looming threats**

PFI and primary care: NHS LIFT .....	18
Pressure to include other services .....	18
The rising tide of NHS costs .....	19

### **Appendices**

1. Major PFI schemes operational and under construction
2. More big NHS schemes in the queue for PFI capital
3. The big costs of smaller PFI schemes

# **PFI in the NHS: a dossier**

**Researched for the GMB by John Lister of London Health Emergency.**

## **Introduction**

Debate over private sector involvement in the financing and delivery of health services has steadily increased over the last few years. Last autumn Health Secretary Alan Milburn signed the controversial “concordat” with private medical providers, under which the NHS will pay for the treatment of waiting list patients in “spare” beds in private hospitals.

In February, Mr Milburn unveiled the latest list of major hospital schemes which he has given the go-ahead to proceed using private funding, as part of the government’s declared goal of establishing £7 billion-worth of hospitals funded through the “Private Finance Initiative” by 2010, as set out in last year’s NHS Plan.

During the election campaign, and in Labour’s election manifesto there was an emphasis on increased “partnership” with the private sector in the provision and operation of hospital services, including the establishment of new stand-alone “health factories”.

This increased involvement with, dependency upon and indebtedness of the NHS to the private sector has been strongly opposed by all of the organisations representing health workers. Among the most vocal critics has been the British Medical Association, which has consistently rejected the core assumptions of the Private Finance Initiative.

As the debate gathers momentum in the run-up to the party conferences in the autumn, this dossier, commissioned by the GMB, is an attempt to bring together and simplify the main elements of the trade union critique of PFI .

It is designed to highlight some of the key reasons why PFI has been and will be opposed by those wishing to maintain and extend levels of patient care, those wanting genuine value for public money invested in public services, those wanting to ensure that health services are accountable to local people, and by organisations committed to defend the interests of health workers and their ability to deliver high quality care for their patients.

**John Lister, 26 July 2001**

## What is PFI?

The initials stand for **Private Finance Initiative**: PFI is a Tory policy, first devised in 1992, which was strongly denounced by Labour's shadow ministers until a few months before the 1997 election.

According to Tory Chancellor Kenneth Clarke, who in 1993 introduced the policy, initially for NHS projects costing £5m or more, PFI means:

**“Privatising the process of capital investment in our key public services, from design to construction to operation.”**

Margaret Beckett, shadow health secretary in 1995, summed up what had become a common line from Labour when she told the *Health Service Journal*

“As far as I am concerned PFI is totally unacceptable. It is the thin end of the wedge of privatisation.”<sup>1</sup>

But in the summer of 1996 Shadow Treasury minister Mike O'Brien announced a change of policy:

“This idea must not be allowed to fail. Labour has a clear programme to rescue PFI.”<sup>2</sup>

By the spring of 1998, PFI was:

“A key part of the Government's 10 year modernisation programme for the health service.”<sup>3</sup>

According to *Guardian* financial columnist Larry Elliott, PFI is “a scam”:

“Of all the scams pulled by the Conservatives in 18 years of power – and there were plenty – the Private Finance Initiative was perhaps the most blatant. ... If ever a piece of ideological baggage cried out to be dumped on day one of a Labour government it was PFI.”<sup>4</sup>

Despite its popularity with ministers, and especially with the Treasury team, PFI has incurred the increasingly vociferous opposition of the BMA, the Royal College of Nursing, almost all trade unions, local campaigners in affected towns and cities, and a growing body of academics.

## So what does the policy involve?

In short, large-scale building projects, which would previously have been publicly funded by the Treasury, were to be put out to tender, inviting consortia of private banks, building firms, developers and service providers to put up the investment, build the new hospital or facility, and lease the finished building back to the NHS – generally with additional non-clinical support services (maintenance, portering, cleaning, catering, laundry, etc).

---

<sup>1</sup> (*HSJ* June 1 1995)

<sup>2</sup> (*HSJ* 22.8.96).

<sup>3</sup> (DoH Press Release 7.4.98).

<sup>4</sup> (*The Guardian*, October 26 1998)

Lease agreements for PFI hospitals are long-term and binding commitments, normally at least 25 years. The NHS Trust involved, which (since the Tory government's "market-style" reforms of 1991) would normally expect to pay capital charges on its NHS assets, instead pays a "unitary charge" to the PFI consortium, which would cover construction costs, rent, support services, and the risks transferred to the private sector.

The big difference from capital charges is that not only are the costs much higher, but PFI "unitary payments", rather than circulating back within the NHS, flow into the coffers of the private companies, from where they are issued as dividends to shareholders.

The appeal of PFI both to the Tories and to the Labour government is that it enables new hospitals and facilities to be built without the investment appearing as a lump sum addition to the Public Sector Borrowing Requirement. The government can appear to be funding the "biggest ever programme of hospital building in the NHS", while in practice injecting less public capital than ever. Only six major NHS-funded schemes, totalling less than £300m, have been given the go-ahead since 1997.

By contrast, the Labour government has so far given the go-ahead to 38 PFI-funded NHS schemes totalling almost £4 billion, and aims to increase this to £7 billion by 2010. The NHS Plan calls for a total of 100 new hospitals.<sup>5</sup> 85% of all new capital investment in the NHS is now coming from the private sector.<sup>6</sup>

But as with all borrowing, the short term benefits of PFI are outweighed by the long term costs. By 2007 the annual cost to the NHS of PFI payments involved in leasing these privately-owned, profit-making hospitals, and buying ancillary services from private contractors, will be in the region of £2.1 billion: together with capital charges, the total bill will add up to £4.5 billion a year.<sup>7</sup>

These – and other, less obvious, costs are being picked up by the taxpayer, by patients, and by hospital staff struggling to keep the service afloat under mounting pressure.

## The extra costs of PFI:

### Increased "headline" costs of schemes

PFI hospital projects have become notorious for the massive level of increase in costs from the point at which they are first proposed to the eventual deal being signed.

In part this is because PFI consortia are keen to make each scheme as big as possible, and also because private firms prefer to buy and then build on greenfield sites and lease buildings back to the NHS rather than refurbish existing NHS hospitals.

Among the more dramatic increases in prices from original plan to PFI deal are:

- **Greenwich:** up from £35m in 1995 to £93m in 1997
- **UCLH, London:** up from £115m to £404m
- **Leicester:** up from £150m in 1999 to £286m in 2001

---

<sup>5</sup> The NHS Plan, July 2000

<sup>6</sup> *The Economics of the Private Finance Initiative in the NHS*, by former Treasury advisor Jon Sussex, Office of Health Economics, April 2001

<sup>7</sup> Will primary care trusts lead to US-style health care? Allyson Pollock, *BMJ* 322, 21 April 2001.

- **South Tees:** up from £65m to £122m
- **Swindon:** a £45m refurbishment of Princess Margaret Hospital in Swindon turned into a £96m new hospital on a greenfield site out by the M4.

The first 14 PFI deals escalated in cost by an average of 72 percent, from a total of £766m to £1,314m by the time they were approved.<sup>8</sup>

This inflation has obviously had an impact on the final bill to be paid. The new **Dartford** Hospital was originally projected to be “at worst cost neutral”, but it soon emerged that purchasers were going to have to foot the bill for an extra £4m a year if the Trust were to be enabled to pay the PFI costs.<sup>9</sup>

### Rate of return for private investors

PFI consortia don't build hospitals for the sake of our health. They want profit for their investment.

A BMJ article in 1999 pointed out that shareholders in PFI schemes “can expect real returns of 15-25 percent a year”, and went on to explain how little actual risk is involved for the companies in PFI consortia.<sup>10</sup> In **Barnet**, the second phase of the new general hospital, originally tendered at £29m, went ahead at a cost of £54m, with capital borrowed at 13% over 25 years. In **Dartford** the rate was 11%, and the £17m annual payment represents a massive 35% of the Dartford & Gravesham Trust's revenue.<sup>11</sup>

The new **Worcester** Royal Infirmary, a project which was originally estimated at £45m when it was first advertised for PFI tenders in 1995, was eventually given the go-ahead at a total cost of £110m. But the annual charge of £17m is more than a quarter of the Trust's projected income. Of this, £7.2m is the “availability” charge, or lease payment on the building, giving a total cost of £216m to rent the hospital for 30 years. The scheme will cost the Worcestershire Health Authority an extra £7 million a year.<sup>12</sup>

While most NHS Trusts spend around 8% of their income on capital, those with PFI schemes are spending between 12% and 16%. In part this is because the private sector has to pay more to borrow money than does the government – but the net result is that the taxpayer picks up an inflated bill, while the banks coin in an extra margin.

### Margins for PFI consortium partners

But the profits flow to the private sector at every level in PFI. Building firms, banks, business consultants and other PFI hangers-on are eagerly anticipating a generous flow of profits as the first hospital schemes take shape.

---

<sup>8</sup> Profiting from closure: the private finance initiative and the NHS, David Price, BMJ 315, 6 December 1997

<sup>9</sup> National Audit Office: The PFI contract for the new Dartford & Gravesham Hospital, May 1999.

<sup>10</sup> PFI in the NHS – is there an economic case? Declan Gaffney, Allyson Pollock, David Price, Jean Shaoul, BMJ 319, July 10 1999

<sup>11</sup> Health Emergency No. 45, November 1997

<sup>12</sup> Worcester Royal Infirmary Full (Approved) Business Case, Vol 1 April 1999

An investigation in the *Health Service Journal*<sup>13</sup> showed building contractors “expecting returns of up to 20 percent a year on the equity stakes they hold in the project companies” as soon as the building is complete and Trusts start paying up for the use of the new buildings. Consultancy firms, too – architects, engineers and surveyors – are pocketing above average fees for work on PFI schemes. As the *HSJ* article pointed out: “there is little chance of the construction industry losing interest in PFI hospitals”.

And once the building is finished, maintaining and providing services in the buildings will deliver comfortable, guaranteed profits of up to 7 percent for firms holding service contracts. The first two waves of PFI hospital schemes all involved the privatisation of any non-clinical support services that were not already in the hands of the contractors.

### Fewer beds

The first wave of PFI hospitals became notorious for the scale of the cuts in bed numbers they represented, with reductions in front-line acute beds ranging from 20% to 40%. PFI planners wanted to axe almost 40% of beds in **Hereford** (from 414 to 250)<sup>14</sup> and **North Durham** (from 750 to 450) – and as a result the newly-opened North Durham Hospital has been plunged into an immediate beds crisis.<sup>15</sup> Two other PFI hospitals embodying large-scale bed reductions have so far opened, in **Dartford** and in **Carlisle**, and both are already struggling to cope with pressures on the depleted numbers of beds remaining.

These bed numbers were based not on the actual experience of front-line Trusts dealing with current levels of caseload, or on any actual examples of hospital practice in this country, but on the wildly over-optimistic projections of private sector management consultants working for PFI consortia.

The verdict is still awaited on one of the other big bed cuts based on this type of approach, in Worcestershire, where the Health Authority forced through plans to for a new PFI-funded **Worcester** Royal Infirmary which would cut 260 acute beds – over 200 of them in **Kidderminster** – as well as beds in **Redditch** – a county-wide cutback of 33%.

In **Edinburgh** the new Royal Infirmary will involve a loss of 500 of the existing 1,300 beds, and a halving of the 6,000-strong workforce.<sup>16</sup>

But campaigners in **West Hertfordshire**, faced with bed cuts on a similar scale, in a scheme to replace **Watford** General and **Hemel Hempstead** hospitals with a new, smaller hospital, were able to persuade their local Labour MPs to rally to the defence of local services. Ministers were forced to intervene and instruct the Health Authority to think again.

Lesser, but significant bed reductions are also involved in most of the PFI schemes currently under construction: **Bromley**'s new £121m hospital will have 13% fewer beds than the hospitals it replaces.<sup>17</sup>

---

<sup>13</sup> ‘Profits for Industry’, *HSJ* 13 May 1999

<sup>14</sup> PFI: Perfidious Financial Idiocy, Richard Smith, *BMJ* 318, July 3 1999

<sup>15</sup> *Guardian* feature July 23

<sup>16</sup> How the Private Finance Initiative reduces the provision of NHS hospital services: three case studies, Dr Allyson Pollock, NHS Consultants’ Association,

<sup>17</sup> Bromley Hospitals Trust FBC

Since the findings of the NHS Beds Inquiry, commissioned by the Labour government to report on the adequacy of bed numbers, Alan Milburn has become more sensitive to the charge that PFI is further reducing front-line capacity.

After intervening (again in the aftermath of a strike) to force the **UCLH** scheme in central London to be expanded to include additional beds (at dramatically increased cost!), Milburn has insisted that new PFI schemes must at least match the existing numbers of acute beds. (Commons statement February 15 2001) This has in turn led to a further escalation in the costs of the new generation of PFI schemes.

One beneficiary of this decision could be the population of **East Kent**, which had been facing a cutback of almost 400 beds in a massive PFI-funded rationalisation scheme that was to axe local A&E units, and reduce acute services from four hospitals to one.

### **Consultancy fees/negotiation costs**

The first 15 PFI schemes for new hospitals spent a combined total of £45 million on advisors, with costs varying between 2.8% and 8.7% of the capital cost of the project. These costs are heavily inflated by the need to strike legally-binding deals with private sector firms in what are often very complicated deals.<sup>18</sup>

This pattern has continued, and according to health minister John Denham the first 18 PFI schemes squandered £53m on consultancy fees – with £24m pocketed by lawyers, £16m to accountants, and £12m spent on “other” advice. **Bromley** Hospitals Trust alone had spent £3m on negotiations by 1997.

The contract for **Coventry’s Walsgrave** Hospital added up to a colossal 17,000 pages in 1996 – at which point the two consortia vying for the deal reportedly asked for government cash to pay lawyers to read it all!<sup>19</sup>

### **Delays in major projects – and in smaller ones, too**

The complexity of the procedures and process of PFI and the negotiations that it involves has brought a new level of delay to schemes which might otherwise have proceeded with public funding.

In **Oxford**, attempts to find PFI capital to relocate and centralise hospital services from the Radcliffe Infirmary to Headington, close to the other main hospitals, have been dragging on since 1996, and already collapsed once.<sup>20</sup> Negotiations on the scheme, originally costed at £71m, have been a closely-guarded secret, as is the latest estimate of the eventual cost.

In **East Kent** NHS Regional bosses have warned that the plans for a new PFI hospital to replace four existing hospitals – the projected cost of which has already almost doubled to £102m – could take 4-7 years to complete the complex PFI process.<sup>21</sup>

---

<sup>18</sup> Evidence to the IPPR Commission on Public Private Partnerships, Section III, UNISON, August 2000

<sup>19</sup> 17,000-page bill of sale, Mail on Sunday, June 23 1996

<sup>20</sup> Hospital Move halted as bidders back out, Oxford Mail Sept 27 1996

<sup>21</sup> Health Emergency No. 53, April 2001

Even more serious have been delays in projects which are smaller, and which do not involve high-profile general hospitals. In London the **Brent Kensington Chelsea and Westminster Mental Health Trust** wants to improve its community services, at a cost of around £24 million: but the project has been log-jammed since 1998. In June the local health authority was told that:

“The Regional Office has said that the Trust must establish whether there is private sector interest in funding and managing the proposed new facilities. ... What seems clear is that the development at Woodfield Road could be more attractive to the market because this is a new development. Schemes that involve refurbishing facilities are less attractive. However the scheme is a small one in cost term and may be below the level at which most companies would be interested.”

If the Trust has to advertise the scheme for PFI bidders, the HA is warned that: “Clearly this could add several months to the timetable. If any part of the scheme is then funded privately the Trust estimates this will add a delay of another 12 months.”<sup>22</sup>

And with consultancy fees so high, and property prices still rocketing upwards in the capital, all this extra time is likely to cost much more money, too.

### Staffing levels reduced

The Cumberland Infirmary scheme involved a cut in clinical staff of £2.6m, and in North Durham the financial balance of the plan involved staff cuts to save £3m.<sup>23 24</sup>

In Bromley, the Full Business Case projects savings in staff costs of £2.9m a year, which arise, among other things, from “the reduction in the number of beds and theatres. 136 jobs are expected to be axed, including 34 nurses and 8.5 doctors, while the reduction in qualified nursing is to be compensated by a higher ratio of health care assistants.”<sup>25</sup>

### Privatisation of support services and staff

In the first few PFI hospital schemes, staff working in non-clinical support services have been routinely “sold on” to private contractors providing “facilities management” for the PFI consortium. Their pay and conditions were safeguarded only by the fragile TUPE (Transfer of Undertakings) rules, which protect only existing staff – leading to a 2-tier system in which new employees are on different term and conditions – and which can easily be circumvented by unscrupulous employers.

In the summer of 1999, after a campaign of strike action, union members at **University College Hospital, London** won a ground-breaking agreement enhancing the protection of the pay and conditions of support staff transferred to the PFI contractors. But staff still stand to lose their entitlement to the NHS pension scheme and sickness payments.

Since the 2001 Election, Alan Milburn – in the aftermath of nearly a year of strike action by support staff at **Dudley Hospitals Trust** fighting their compulsory transfer to a private

---

<sup>22</sup> Papers for Kensington Chelsea & Westminster Health Authority (report HA(01)30.2), June 13 2001

<sup>23</sup> “The only game in town? A report on the Cumberland Infirmary” Price, D, Gaffney D, Pollock A, UNISON December 1999

<sup>24</sup> Downsizing for the 21st Century, Declan Gaffney & Allyson Pollock, UNISON

<sup>25</sup> Bromley Hospitals Trust FBC section 13 (pages 97-98)

contractor as part of a PFI deal – has now announced three “pilot” schemes, in which support services will be separated from the financing of the new building.<sup>26</sup>

However hospitals which have already been cleared to proceed with schemes incorporating support services will be allowed to go ahead, and it appears that the management of support services could still be handed to the private contractors, while the staff they manage remain employed by the NHS.

It is not yet clear whether the PFI consortia will agree to this loss of what they saw as a valuable additional income stream. It is possible they will respond by seeking to increase other charges to compensate for the loss of additional profit.

A document for the **Barts and the London Trust**, discussing the so-called “Soft Facilities Management” services (portering, cleaning, catering and laundry) pointed out that “Potential bidders view the inclusion of Soft FM services as important to making the Trust’s Project attractive”.

In a document larded with management jargon, the Trust board were also told – contrary to all the experience of NHS staff who have been switched to private contractors – that: “There are potential benefits for the staff concerned ... Terms and conditions may be better than the NHS can afford to offer.” [!!] “Transferred staff will be part of a larger, specialist FM provider organisation which can enhance career progression and provide better training and development.”<sup>27</sup>

### **“Railtrack on the wards”:** fragmenting the health care team

The privatisation of support services under PFI – normally to a company which itself is part of the PFI consortium – continues down the long and discredited road of fragmenting the NHS care team which began with the Tory government’s imposition of competitive tendering in the mid 1980s.

Private firms seeking to make profits from labour-intensive services have always sought to do so by reducing staff pay and conditions, reducing the numbers of staff and hours worked, and increasing the workload on each low-paid member of staff.

Private companies are responsible for the cleaning (or lack of it) in almost all of the country’s ten dirtiest hospitals, and there has been a non-stop succession of failures to deliver quality services. According to a ministerial answer last summer, there have been 57 incidents since 1997 in which the quality of privately-delivered NHS support services has dropped to such a poor level that Trusts have invoked penalty clauses. Penalties totalling £1.9 million have been imposed, while 14 of these contracts have been terminated.<sup>28</sup>

The NHS Plan has acknowledged that the privatisation of services so vital for the quality of patient care causes real problems, and ministers have pledged to alter contracts to make

---

<sup>26</sup> Soft Services in PFI Projects: the Retention of Employment Model, Circular from Peter Coates DoH PFIC, June 21 2001.

<sup>27</sup> Papers for Barts & London Trust Board meeting on March 14 2001

<sup>28</sup> Hansard June 13 2000

support staff employed accountable to nursing and medical staff: but so far there is little evidence that this will work.<sup>29</sup>

### **Loss of additional income (car parking, shops, catering, etc)**

In the new **North Durham** hospital, the WRVS volunteers to pay rent to the PFI consortium for space in the new building, while patients have to fork out up to £25 per week to watch the new bedside TVs.<sup>30</sup>

These are just some of the changes that will be ushered in when private firms own the hospital and its surrounding facilities. Car parking charges and rent from shops, cafes and restaurants on the hospital site, which might previously have gone to the Trust, are now another income stream for the PFI consortium.

These services also move out of the control of the Trust: in **Cardiff**, the new PFI-funded car park at the giant **University Hospital of Wales** now levies punitive charges on patients and visitors, backed up by zealous imposition of fines of up to £25, regardless of the circumstances. The Trust is powerless to intervene.

### **Squeeze on clinical staff**

The inclusion of all non-clinical support services in rigid, legally-binding “unitary payments” effectively top-sliced from Trust budgets under PFI creates a new pressure on staff in clinical services.

Clinical services become the only area of Trust spending where Trust managers can seek the “cost improvements” and “efficiency savings” which they are required to make each year by government and by NHS purchasing bodies.

As the **Wellhouse** Trust was told in the negotiations over the new **Barnet General** Hospital – where even medical records have been incorporated into a PFI contract in a new computerised system:

“Part of the price ... has been to agree to an indexation regime which has no in-built cost improvement and is linked to the published RPI index ... The Trust will not therefore be in a position to impose Cost Improvement Programme targets across most of its support and operational services. ... The scope for future mandatory CIP targets will be limited to clinical services and to the few support services remaining under the management of the Trust.”<sup>31</sup>

### **Squeeze on community and other services**

If more has to be spent in paying inflated costs of building new acute hospitals through PFI, less cash is left in the pot to finance other aspects of health care in each area.

As we have seen, many of the first wave of PFI hospitals have had to be heavily subsidised by local health authorities in order to make them affordable. The **Worcestershire** scheme means

---

<sup>29</sup> The NHS Plan, Chapter 4, July 2000

<sup>30</sup> Crisis hit hospital finds that finance for the NHS comes at a price, *The Guardian* July 23, 2001

<sup>31</sup> Report to Barnet Health Authority, Bob Green Deputy PFI Director, July 23 1997

that an extra £7 million is being allocated to acute services to enable the Trust pay for the new WRI: this has to be found by squeezing cash allocations for mental health, community services and primary care.

## Poor quality buildings

Much of the argument in favour of allowing the private sector to own and manage as well as build new hospitals, and for the long terms of lease agreements under PFI has been that the result will be a higher-quality building. Unveiling the latest round of PFI schemes receiving the rubber stamp, Alan Milburn argued that:

“For too long investment in NHS infrastructure has been a low priority when it should have been a high priority. Capital investment in the NHS was lower at the end of the last Parliament than it was at the beginning. The consequences are plain for all to see. Buildings that are shoddy, equipment that is unreliable, hospitals that are out of date. In too many places the environment that staff work in and patients receive care is simply unacceptable.”<sup>32</sup>

But the experience has been NEW buildings which are shoddy and NEW equipment that is unreliable – at a higher price than before. After just a few months of the first PFI hospitals coming on stream:

- In **Carlisle**, a chapter of disasters and catastrophes began with an impractical design – with a huge glass roof, but no air conditioning – and continued with the use of cheap sub-standard plastic joints for pipes, resulting in leaks of water and sewage. Faulty equipment and fittings have brought a succession of power cuts, while cuts in support staff have meant that broken equipment goes unrepaired. Walls are too thin for staff to be able to put up shelves.<sup>33</sup>
- In **Dartford**, too, plumbing was a central issue in the new hospital. Taps ran dry in operating theatres a fortnight after the hospital opened, and supplies of sterilised supplies ran out, bringing elective surgery to a halt. Consultants complained that the portering contract did not cover wheeling patients back to wards after operations.<sup>34</sup>
- In **North Durham** the saga continues, with generator failures plunging operating theatres ITU and casualty into darkness, overheating, poor planning, and plumbing faults which include sewage flooding through ceiling areas and cold taps that give out hot water.<sup>35</sup>

Trust managers in response to the *Observer* article detailing the problems in Carlisle hit back arguing that the standard of the PFI building and the “teething problems” of the new hospital were no worse than normal in new NHS-funded hospitals (all of which of course are built by private construction firms). Critics point out that simply being no worse than new NHS-funded buildings, does not seem to justify the extra cost and other problems of PFI.

## Land assets stripped: NHS as tenant

Many PFI deals are part-funded by handing over to the consortium “spare” NHS land and building assets released as part of the new scheme. Although this defrays some of the initial

---

<sup>32</sup> (DoH Press Release Feb 15 200 1)

<sup>33</sup> Filthy, gloomy and chaotic: the reality of the new NHS, Anthony Browne, *Observer*, July 8 2001

<sup>34</sup> Shambles at £177m Hospital, Zoe Morris, *Evening Standard* 25 August 2000.

<sup>35</sup> Crisis hit hospital finds that finance for the NHS comes at a price, *The Guardian* July 23, 2001

costs – and therefore reduces the monthly “unitary charge” which it must pay, the Trust then becomes a tenant, renting its key acute facilities from the private sector.

This has two important consequences for the future:

1. Once the NHS assets – paid for over the generations by the taxpayer – have been passed over in this way, the Trust no longer has any scope to use them in future service developments. The initial cost of any future schemes will inevitably be higher – and the probability of having to seek additional financial investment from the private sector is increased. And at the end of the contract period, the NHS Trust is likely to be in a weak position to negotiate over a further extension of the lease agreement.
2. The PFI deal effectively locks the Trust in to a long-term commitment to maintain services around the new hospital or PFI-funded facilities – no matter what changes may take place in local health needs, medical techniques or population over the next 25-60 years. The flexibility of owning land and buildings and being able to take decisions over how they should be used is seriously reduced.

### **Refinancing: another private sector rip-off**

Attention has recently focused on the huge bonus profits which can be made by PFI companies which refinance the deal as soon as the most “risky” phase – of constructing the hospital – is complete.

In the case of the **Norfolk & Norwich** Hospital, a possible £70 million figure has been floated, on a deal worth £229m. The deal is even more amazing when we realise that the five firms behind the Octagon Healthcare consortium invested just £30m of their own money in the project.<sup>36 37</sup>

Another NHS hospital expected to yield a healthy hand-out for shareholders is **Dartford**, where the refinancing gain could be £20m – with no provision for any public sector clawback.<sup>38</sup>

This loophole for profiteers, apparently well-known to PFI bidders, was not addressed in many of the early PFI projects endorsed by the government: indeed the Treasury Taskforce strongly discouraged authorities from seeking any share of the bonus cash that could be secured. As a result, out of 82 public sector PFI deals, with a value of £9.7 billion, only 15 had any “claw-back” provision to ensure that future windfall savings were shared. Out of the £10.7 million produced by the refinancing of the Fazakerley prison contract, the prison service secured only £1m, while the rate of return on the deal for shareholders of Group 4 and Carillion trebled to 39%.<sup>39</sup>

As more PFI hospitals come on stream, we can expect a succession of refinancing deals to surface, within which the NHS Trusts will receive at best only a token portion, underlining once more how unequal is the “partnership” and “risk sharing” between public and private sectors.

---

<sup>36</sup> Who picks up the bill? David Smith, Sunday Times 15 July 2001

<sup>37</sup> Bleeding the hospitals, George Monbiot, The Guardian 5 June 2001

<sup>38</sup> (*Observer* 8 July 2001)

<sup>39</sup> Evidence to the IPPR Commission on Public Private Partnerships, Section III, UNISON, August 2000

## “Hidden”, non-financial costs

### Planning distorted

Under PFI, NHS managers and professionals play no role in planning hospitals: this is delegated to the private sector. Instead the Trust draws up an invitation to negotiate and an “output specification”, which does not state how many beds should be provided but the anticipated level of clinical activity. It is left up to any consortia which respond to the invitation to propose the numbers of beds and scale of the services to be provided.

But any publicly funded option must show itself to be comparable to PFI in “efficiency” and value for money: the inevitable consequence in the first round of PFI deals was a dutch auction on bed reductions, led by the most gung-ho private sector management consultants.

In **Worcestershire**, for example, the management consultants drawing up the scheme pointed out – without any evidence to support their assertion, other than other PFI schemes – that “many acute service reviews and proposed hospital business cases have assumed that future targets of between 8-10 beds per 1,000 in-patient episodes are feasible.”

But they did not explain how this might be achieved in practice, or point out that to work on these assumptions in Worcester Royal Infirmary would amount to a 40 percent increase in throughput for each bed. To make matters worse, another firm of business consultants extended the same assumptions to the other acute hospitals in Worcestershire: it was on this fragile basis that the HA decided it could close down 229 acute beds at Kidderminster Hospital, 30 in Redditch and over 100 in Worcester. Even the HA’s own advisors warned that achieving these bed capacity targets across the county “would be a major challenge”.<sup>40</sup>

Throughout the NHS bed throughput has largely levelled off at around 56-57 patients per bed per year. The PFI plans for **Edinburgh** Royal Infirmary aimed to increase this to a massive 88: but the Worcestershire plans aimed at almost doubling the national average, to over 100 patients per bed per year. The driving force in this was PFI.<sup>41</sup>

Such a big increase in throughput per acute bed in **Worcestershire** or elsewhere could only be achieved by discharging more patients to less intensive, “intermediate” or “step-down” beds. But this calls for additional investment in community health services and an expansion of these beds: the apparent increase in “efficiency” of the PFI hospital can only be achieved if it is effectively subsidised by increased spending elsewhere. Unfortunately this investment is less likely to be forthcoming because of the increased costs of renting and running the PFI hospital.<sup>42</sup>

This was the scheme in **North Durham**, where the new PFI hospital was projected to treat fewer patients, while costing the health authority £1.5m more, in addition to the costs of buying additional beds in community hospitals to fill in the gaps.

---

<sup>40</sup> Casting Care Aside, a response to Worcestershire Health Authority, John Lister for Wyre Forest District Council, May 1998.

<sup>41</sup> Profiting from closure: the private finance initiative and the NHS, David Price, BMJ 315, 6 December 1997

<sup>42</sup> Casting Care Aside, a response to Worcestershire Health Authority, John Lister for Wyre Forest District Council, May 1998.

Health chiefs reluctant to abandon their hopes of a new hospital may, as in Worcestershire, try to gloss over or conceal these contradictions, but as the North Durham example shows, the inadequacy of the final provision will eventually come back to haunt them.

### **Accountability weakened**

Secrecy is a key ingredient in the whole process of PFI. Once a decision to negotiate has been taken, all of the detailed discussions about the shape, size, cost and service profile of the hospital take place behind firmly locked doors.

In 1998 Health Secretary Alan Milburn announced with a flourish that Trusts would be required to publish “all the key PFI project documents. This includes documents covering existing PFI deals. This gives local people and local staff a new right to know about the future of their local health service.”<sup>43</sup> The reality has been very different. Deals are being done with no publicity until after the details have been agreed and binding agreements made. Often the details are still withheld from the public even after a deal has been closed.

Even MPs have found it hard to get at the facts. When the Commons Health Committee asked for details on the **Norfolk & Norwich** PFI scheme in 1999, they were given copies of the “full business case” with large sections withheld as “commercial in confidence”.

And when BBC documentary producer John Mair tried to find out 18 months later what the unitary charge was going to be for the N&N, he found a discrepancy of over £13m a year between the lowest estimate (£22.8m) and the highest (£36m), and even over how many years the charge would be payable. Chief Executive Malcolm Stamp was unable to answer the question, or put a price on the whole deal.<sup>44</sup>

Worcestershire Health Authority, unable to answer awkward questions from local campaigners on how the smaller **Worcester Royal Infirmary** could cope with county-wide demand, refused in its response to the consultation even to mention that the questions had been asked. It preferred to fight campaigners all the way to a judicial review, and then hide behind the cavalier ruling of a reactionary judge rather than answer or give details.

Health Authorities and Trusts are quango bodies, appointed by government, without any direct or democratic accountability to local people. But those planning the new PFI-funded hospitals are even less accountable, unknown to the public. To make matters worse, they have no obligation to consider the knock-on effects of their plans on other health services in the area or surrounding areas.

Finished Business Cases are only published after they have been signed – and even then some details may be withheld on grounds of commercial confidentiality. As the National Audit office found in the case of the **Dartford** PFI hospital, there is ample scope for purchasers and NHS Trusts to make very large and expensive mistakes with little detailed scrutiny until it is far too late to affect decisions that then last for 25-60 years.<sup>45</sup>

### **Potential for corruption**

---

<sup>43</sup> DoH Press Release April 8 1998

<sup>44</sup> *Public Finance*, Dec 1-7 2000

<sup>45</sup> National Audit Office: The PFI contract for the new Dartford & Gravesham Hospital, May 1999.

Describing PFI as “Perfidious financial idiocy”, BMJ editor Richard Smith has pointed out that the schemes create “generous scope for corruption”:

“The ingredients are all there: big sums of public money; closed decision making and inadequate accountability; and “consultants” jumping backwards and forwards from the private to the public sector. Sooner or later we will have a scandal.”<sup>46</sup>

### **Voters say “no thanks” to PFI**

Where they have been given a chance to do so, voters have shown that they reject the arguments put forward for PFI by ministers and health chiefs. The election of hospital campaigner Richard Taylor, overturning the sitting Labour MP and winning with a massive majority in Wyre Forest, is just the latest expression of bitter popular resentment at the PFI scheme that has closed acute services at **Kidderminster** Hospital in order to fund a new, smaller hospital 30 miles away in Worcester.

In **Wakefield** in 1999, trade unionists and campaigners invoked a little-known clause in the Local Government Act of 1972 to trigger a local referendum on the PFI issue, in which a staggering 81 percent of voters said that if no public funding was available they would rather see no new local hospital than one funded privately.

Opinion polls continue to confirm that the vast majority of the general public are opposed to greater private sector control or management of the NHS.

### **How does PFI show “value for money”?**

#### **Untested assumptions**

As we have shown above, the inability of the first PFI hospitals to meet pressures for emergency and elective work with substantially fewer beds has already been exposed. In **North Durham**, within 12 weeks of the new hospital opening there have been calls for an additional 42 beds to be provided to prevent patients enduring 12-hour waits in A&E.<sup>47</sup>

But their ability to deliver dramatic increases in efficiency has always been seen as key to the affordability of PFI hospitals, and the principal way in which they can defray the additional money they cost the Trust.

As the full financial cost of operating the new system – including the use of increased numbers of community beds and services – is counted, the underlying false assumptions will be fully revealed and the heavy price of PFI will be revealed.

The next generation of PFI hospitals, embodying Alan Milburn’s call for schemes to be at least “bed neutral”, or embody an increase in bed numbers, will find it even harder to show that they offer value for money.

#### **“Only game in town” – NHS investment cut**

---

<sup>46</sup> PFI: Perfidious Financial Idiocy, Richard Smith, BMJ 318, July 3 1999

<sup>47</sup> New hospital with too few beds ‘grossly inadequate’, The Guardian, 12 July 2001

Perhaps the strongest card in the hands of PFI consortia in justifying their plans and the high costs involved has been given to them by the government – effectively pulling out of the public funding of new hospitals, and confirming the management view that for those wanting investment PFI is “the only game in town”.

While deals have been done worth billions with the private sector, only a handful of major schemes were given NHS capital funding during the first term of Labour government – **Gloucester** (£25m), **Royal Berks and Battle, Reading** (£74m), **Sheffield** (£24m) **Guy’s and St Thomas’s** (£52m) and **Hull RI** (£20m).

The logic of this is that any redevelopment to services to increase efficiency and eliminate backlog maintenance must necessarily involve the private sector.

### **NHS innovation excluded**

Any Trust seeking PFI investment has to depend upon the private sector to suggest the best way of meeting estimated clinical activity, leaving scope for innovative developments. By contrast, any public sector comparative scheme is required by the Treasury to be “based on the recent and actual method of providing that defined output (including any reasonable and foreseen efficiencies the public sector could make)”.<sup>48</sup>

This is especially ironic when we see the quite unreasonable and unrealistic assumptions on which some of the PFI schemes have been based.

### **Cooking the books: “Public Sector Comparator”**

Every PFI scheme is supposed to prove that it represents value for money by being contrasted with a “Public Sector Comparator. But it is clear from the outset of such an exercise that the comparison is not between like and like: the investment of energy and commitment into selling the PFI scheme to attract the only likely source of funding will not be matched by the ritualistic development of a hypothetical and unloved alternative, whose main virtue is to appear less attractive.

Government guidance spells out that the public sector scheme is not as a real plan for a real hospital but just a fig leaf to hide the blushes of the PFI plan: “The purpose of the PSC is to provide a benchmark against which to form a judgement on the value for money of PFI bids”.<sup>49</sup>

In **Dartford** the National Audit Office subsequently found that the exaggeration of the costs of the PSC by a massive £12m meant that only a fraction of the expected £17m savings in comparison with a traditional project could eventually materialise.<sup>50</sup>

### **Discounting the future**

---

<sup>48</sup> Public Accounts Committee Twelfth Report: The PFI Contract for the new Dartford and Gravesham Hospital, March 2000

<sup>49</sup> Public Accounts Committee Twelfth Report: The PFI Contract for the new Dartford and Gravesham Hospital, March 2000

<sup>50</sup> National Audit Office: The PFI contract for the new Dartford & Gravesham Hospital, May 1999

One of the manipulative techniques that works consistently to the advantage of a PFI deal in comparison with the PSC is the calculation of the “net present costs”. This assumes that money spent now is worth more than money spent in five, ten or twenty years time – and that the full costs of a hospital development will be paid in the first few years of the scheme (when the value is highest) while the costs of a PFI deal can be defrayed over the whole life of the contract.

On one level this is true, given the effects of inflation and the costs of borrowing a large sum up front. But the exercise is made surreal by selecting an arbitrary, and high, level of 6% per year – well above current and projected levels of inflation – as the basis for discounting the value of future payments (which in any event are index-linked, and do not diminish but increase each year to keep pace with inflation). By this measure, £100 of expenditure in five years has a present value of £74.73, and in 20 years £31.18. Even a small (0.5%) reduction in this “discount rate” would be enough to wipe out the claimed economic advantage of the Carlisle hospital PFI.<sup>51</sup>

A former Treasury advisor has suggested a much more realistic figure would be 4%: but such a discount rate would leave most PFI deals clearly more expensive than the PSC.<sup>52</sup>

### “Risk transfer”

To further stack the odds in favour of the PFI option, the costs of the Public Sector Comparator (PSC) are commonly loaded to compensate for “risks” allegedly transferred to the private sector consortium under the PFI deal. It is often only after this and other statistical sleight of hand that the PFI option can be shown as even marginally better value than a publicly-funded scheme.

Among the “risks” which are given a cash value and added to the cost of the PSC, most relate to the first stage of the project, the actual construction of the hospital itself – a process that has never been directly under the control of the NHS.

The central risk in this phase is that of cost over-runs. But while the average over-run of eventual building costs in NHS projects has been between 6% and 8.5% for the last 10 years, PFI business cases assume much higher levels of 12.5% or up to 34% in the **Norfolk & Norwich Hospital**.

Other “risks” which are given a notional cash value and added to the cost of the public sector comparator are either similarly inflated or fictional – such as the £5m added to the Carlisle PSC to compensate for the “risk” that clinical cost savings would not be made, despite the fact that the consortium is under no obligation to compensate the Trust if this occurs.

### Subsidies – open and covert

To further stir the pot of obfuscation on the genuine comparative costs between a privately-funded hospital and a publicly funded project, a variety of subsidies can be openly or covertly slipped in.

---

<sup>51</sup> Gaffney, Pollock et al, BMJ 319 10 July 1999

<sup>52</sup> *The Economics of the Private Finance Initiative in the NHS*, Jon Sussex, Office of Health Economics, April 2001

As with the examples of **Worcestershire** and **North Durham**, the subsidies may be implicit, in the requirement for a large increase in spending on community hospitals and community health services to create a new system of care that may or may not allow the new hospital to deliver its target of much more rapid throughput.

Or subsidies may take the form of “smoothing” payments from a special slush fund held by the NHS Executive, effectively providing a direct subsidy for the introduction of the PFI scheme where it is clear that there is insufficient cash in the local kitty to pay the increased costs. In 1997 Gaffney and Pollock listed annual payments totalling £7.3m under such “smoothing” mechanisms.<sup>53</sup> The new **Dartford** Hospital was only affordable with the injection of an extra £1m a year: even now the PFI bill accounts for around a third of the Trust’s revenue.

### **Myths of “efficiency” and “commercial disciplines”**

Beneath the veneer of hard-headed business rhetoric and technical jargon the myths that the private sector can usher in greater “efficiency” and “commercial discipline” lack any real substance or evidence.

## **Looming threats**

### **PFI and primary care – NHS LIFT**

While conventional PFI siphons profits from big developments such as hospitals, another aspect of the NHS Plan, the Local Investment Finance Trust (the so-called “NHS LIFT”) sets out to rebuild much smaller units – GP surgeries and health centres.

Alan Milburn has claimed that this new company will “lever in” a £1 billion investment in these premises over the next three years: but only £175m of this new money will come from the Treasury: the remainder will be from the private sector, which will expect a substantial guaranteed return for years to come.<sup>54</sup>

There are already indications that large companies eager to cash in on closer links with the NHS and with primary care (such as Boots) may be interested in such schemes, while GPs, already independent contractors effectively running small businesses, will be further steered into fuller-scale identification with the private sector.<sup>55</sup>

### **Pressure to include other services**

The government’s election pledge to set up specialist free-standing surgical units was linked to suggestions that some or all of these might be built jointly with, or run by, the private sector.<sup>56</sup>

---

<sup>53</sup> Can the NHS afford the Private Finance Initiative, Declan Gaffney and Dr Allyson Pollock, BMA Dec 1997.

<sup>54</sup> NHS LIFT, PFI Home page, DoH web site, April 2001

<sup>55</sup> How private finance has triggered the entry of for-profit corporations into primary care, Pollock et al, BMJ 322

<sup>56</sup> Ambitions for Britain, Labour’s manifesto 2001, p 22

This would raise once again the thorny issue of the employment of clinical staff – nurses, doctors and professionals – by private firms or PFI consortia, a policy which successive Labour health secretaries have insisted they would not implement.

However the building of new units would open up the possibility that rather than transferring staff from the NHS to a private employer, staff might simply be recruited to a privately owned and managed unit, conducting work on contract for the NHS – as indeed will an increasing number of private hospitals as a result of the government’s Concordat signed last year.

Private sector companies have long pressed for the extension of PFI into a number of clinical areas including radiology and imaging services, pathology, and specialist nursing. In April 2000 the **Welsh Assembly** intervened to block plans that would have transferred NHS nursing staff at **Glan Clwyd** hospital near **Rhyl** to Fresenius, a private firm that was preferred bidder for a new renal and dialysis unit.<sup>57</sup>

### The rising tide of PFI costs

NHS schemes completed, under construction, or on the list for approval between now and 2006 already add up to a staggering **£6.4 billion**, and a quick look at the tables in the Appendices below shows that the sums of money committed in terms of annual payments are far larger than that, with most deals lasting 25 years or more.

Adding up the data from the tables shows that the combined unitary payments on the six PFI hospitals which are already operational adds up to **£83m** a year, giving a total payable of £2.4 billion – **SIX TIMES** the capital value of £423m.

The annual fees on the next 14 schemes in the queue for which details are available add up to **£250** million a year, giving a total cost of £7.9 billion – over **FIVE TIMES** the capital value of £1,507 million.

If these deals are replicated in subsequent PFI schemes, the NHS could wind up paying between £32 billion and £38 billion in real terms (index linked payments) to private consortia over the next 25-30 years.

The argument that support services are included in this overall cost falls flat when we contrast this cost of financing a project through PFI, in which every £1m of capital eventually costs £5-£6 million, with a standard 6% mortgage. Every £1m could be financed this way over 25 years for just **£1.94 million, less than double** the amount borrowed, and with no obligation to buy any other services, and freehold tenure of the assets at the end of the deal.

The NHS is only part of the total PFI borrowing. As *Sunday Times* correspondent David Smith pointed out recently, based on the Treasury’s budget report, with deals worth £14 billion already generating revenue:

“Even if no new PFI deals were signed, the government would pay nearly £4 billion a year, on average, in fees and charges to PFI contractors over the next 25 years.”<sup>58</sup>

---

<sup>57</sup> Health Emergency No.53, April 2001

<sup>58</sup> *Sunday Times* July 15 2001

## PFI in the NHS: A Dossier

Of course the private sector is keen to ensure that even more deals are signed, with the potential to crank up revenues from the state for the whole gamut of PFI deals towards the £30 billion a year mark.<sup>59</sup>

But how does all this represent value for the public sector? While the headline and actual costs of the large schemes are big enough to cause long-term dislocation to the finances of the NHS, the cumulative costs of financing some of the smaller schemes (less than £20m) through PFI (see analysis attached) can be ludicrously large.

Some small scale deals which ought to be affordable from one-off capital funds are to be paid off over 25 or 30 years, with a resultant cost as high as 24 times the value of the scheme. (figures below are taken from Department of Health data, "PFI schemes by Region": "total cost" is obtained by multiplying the – index-linked – unitary payment with the number of years in the contract.)

- **Queens Medical Centre catering:** value £1m total cost **£23.8m**
- **North Birmingham Mental Health:** value £12.4m, total cost **£163.5m**
- **Royal Wolverhampton Radiology:** value £10.9m, total cost **£70m**
- **Rotherham Priority Elderly MH:** value £2.1m, total cost **£16.9m**
- **North Bristol Brain Rehab unit:** value £4.9m, total cost **£42m**

In some cases, management will argue that even these small-scale PFI deals represent much more than a costly hire-purchase scheme, and that significant services are included as part of the unitary payment. But the combined deal is only available with this fixed, real terms price tag, and the value for money must be assessed in the context of the final cost compared with the initial investment.

The figures suggest that financing piecemeal schemes in this way, with all of the on-costs of bureaucracy and delays, cannot be a sensible use of NHS resources.

The more money that is squeezed out of the NHS in PFI payments to bankers and private providers, the less that remains to treat patients, pay clinical staff and develop modern, appropriate services.

**Researched and compiled for the GMB by John Lister  
(London Health Emergency)  
July 26, 2001  
020 8960 6466  
07774 264112**

Appendix 1

---

<sup>59</sup> Private sector lured by £30bn gold rush, Allyson Pollock, Observer, 8 July 2001.

<b>Major PFI Schemes operational</b>			
<b>NHS Region</b>	<b>Scheme</b>	<b>Value £m</b>	<b>Comment</b>
SE	Dartford & Gravesham	94	Funded cost £133m. 30 year deal at £17.15m would cost £514m.
SE	South Buckinghamshire	45	29 year deal at £8.38m a year, giving total cost of 243m
London	Greenwich	93	This refurbished military hospital is being rented at an annual fee of £16.82m, giving a cost over 30 years of £505m.
Northern & Yorkshire	Carlisle	65	30 year deal at £12.3m, giving a total cost of £369m.
N&Y	Calderdale	65	Funded cost £107m. Unitary payment of £15.25 over 30 years adds up to £457m
N&Y	North Durham	61	Funded cost £111.8m 27 year deal at £13.61m will cost £340m
Total schemes operational		423	
<b>Major schemes under construction</b>			
London	Bromley	118	Unitary payment of £21.42m pa, giving total cost of £637m over 30 years. No completion date given
London	Barnet	54	Cost escalated from £29m. Unitary charge of £14.86m, giving total cost of £446m over 30 years. No completion date given
London	St George's	49	35 year contract, with annual fee of £6.8m, total payable £238m
London	UCLH	404	35 year deal to 2040, at £32m pa, giving total cost of £1.12 billion. A 6% mortgage would pay off £404m at the same annual fee in less than 25 years, for just £781m.
London	West Middlesex	60	No financial figures available
London	King's	64	34 year deal to 2037, at £17m per annum, giving total cost of £578m.
Eastern	Norfolk & Norwich	158	Total funded cost £228m. Unitary payment £35.3m over 30 years, would give cost of 1.06 billion.
West Midlands	Dudley Hospitals	137	Dramatic leap in costings from original £62m. Unitary payment of £26m over 37 years to 2041 will give total cost of £962m.
West Midlands	Worcestershire	87	The new smaller hospital will cost £17m a year over 31 years, a total of £527m
West Midlands	Hereford	64	Unitary payment of £8.63m over 26 years, to give a final cost of £224m
S West	Swindon	96	Total funded cost £138m. Unitary payment of £15.76m pa, giving total cost of £425m by 2029
N. West	South Manchester	66	Funded cost is £105m but this is a very

## PFI in the NHS: A Dossier

			expensive deal: Unitary payments of £15.3m over 33 years, to give a total of £504m
N&Y	South Durham	41	Funded cost £65m: unitary payments of £8.27m a year over ? 30 years brings a cost of £248m
N&Y	South Tees	122	Funded cost £155m. Unitary payment £23,83m over ? 30 years would give total cost of £715m.
N&Y	Leeds Community	47	Unitary payment of £8.12 over ? 30 years brings cost total to £244m.
N&Y	Hull & E Yorks	22	No financial details
SE	West Berks Priority	30	No financial details
<b>Total under construction</b>		<b>1619</b>	
(Values as stated by DoH, May 21, 2001.)			

Data from Department of Health websites, especially PFI Schemes by Region, and DoH Press Release “Long Term Investment to build 21st Century NHS (15 Feb 2001)

<b>More big NHS schemes in queue for PFI capital</b>				
<b>NHS Region</b>	<b>Trust</b>	<b>Project</b>	<b>Value £m</b>	<b>Comment</b>
Eastern	Essex Rivers	Centralise acute services	79	No dates
Eastern	Mid Essex Comm	Centralise services	80	No dates
Eastern	Peterborough	Centralise acute services	135	First costed at £54.5m in 1997.
<b>Eastern Totals</b>			<b>294</b>	
London	Lewisham Hospital	Redevelopment	44	No dates
London	SW London	St Mary's, Roehampton	20.5	Finalise Sept 01
London	Havering Hospitals	New DGH	148	Finalise Dec 01
London	The Whittington	Acute redevelopment	23	Finalise Nov 01
London	Barnet & Chase Farm	Chase Farm reconfiguration	41	No dates
London	NW London Hospitals	Redevelop Central Middlesex Hospital	56	No dates
London	Forest Healthcare	Redevelop Whipps Cross Hospital	184	No dates: Trust under financial pressure
London	Newham Healthcare	Rationalisation	20	Finalise Oct 01
London	North Middlesex Hospital	Redevelop site	73	No dates
London	Barts & the London	Acute site rationalisation	620	First costed at £250m to rebuild Royal London
<b>London Total</b>			<b>1229.5</b>	
W Midlands	Walsgrave Hospitals	New DGH	178	Payments of £36m, total cost £1.12 bn by 2032.
W Midlands	Royal Wolverhampton Hospitals	Redevelop acute hospital site	110	Payments of £19m pa, total cost £494m by 2034
W Midlands	Walsall Hospitals	Reprovision of acute, mental health & community	37.7	Payments of £7.6m pa gives total of £205m by 2033
W Midlands	University Hospital Birmingham	Reprovision of acute services on one site	291	Annual payments of £50m, total cost £1.25 bn by 2033
W Midlands	North Staffordshire Hospital	Reprovision of acute services on one site	224	Annual payment £36m, total cost £900m by 2033
<b>W Midlands Total</b>			<b>840.7</b>	

PFI in the NHS: A Dossier

N West	Blackburn Hyndburn & Ribble Valley	Site Rationalisation	65.6	Finalise Nov 01
N West	Tameside & Glossop	Site Rationalisation with primary care-led A&E	43	No dates
N West	St Helens & Knowsley	Modernisation of 2 major and 4 primary care sites	211	No dates
N West	Salford	Site Rationalisation	114	No dates
N West	Central Manchester	Reconfiguration	199	Finalise July 02
<b>North West total</b>			<b>632.6</b>	
N&Y	Pinderfields & Pontefract	Modernisation	164	Finalise May 03
N&Y	Bradford Hospitals	Modernisation	116	Finalise March 03
N&Y	Leeds Teaching Hospitals	Acute services reconfiguration	119	No dates
N&Y	Newcastle upon Tyne Hospitals	Complete reconfiguration of acute services	123	No dates
<b>Northern &amp; Yorkshire Total</b>			<b>406</b>	
South East	Southampton University Hospital	Phase 2 cancer service relocation	52	No date
South East	Maidstone & Tunbridge Wells	Acute hospitals reprovion	187	No date
South East	East Kent Community	Acute hospitals reconfiguration	102	No date
South East	Oxford Radcliffe Hospitals	Cancer services scheme	27.6	No date
South East	Oxford Radcliffe Hospitals	Reprovide Radcliffe Infirmary	71	No date
South East	Nuffield Orthopaedic Centre	Redevelopment	23.6	Under construction
South East	Stoke Mandeville	Partial redevelopment	23.7	Finalise Nov 01
South East	Brighton Health Care	Paediatrics to Royal Sussex County Hospital	25	No date
South East	Portsmouth Hospitals	Acute rationalisation	75	Finalise Oct 02
South East	Sussex Weald	Graylingwell Hospital reprovion	22	Annual payment £3.38m: cost £81m by 2025
<b>South East Total</b>			<b>608.9</b>	
S West	South Devon	Torbay DGH etc	65	Finalise Oct 04
S West	Gloucestershire Royal	Site redevelopment	33.5	Finalise Dec 01
S West	Avon & W Wilts Metal Health	Bristol mental health	48	Finalise Nov 03

## PFI in the NHS: A Dossier

S West	Plymouth Hospitals	Derriford Care centre	101	Finalise June 04
S West	United Bristol	Bristol acute services	104	Finalise June 03
<b>South West Total</b>			<b>351.5</b>	
Trent	University Hospitals of Leicester	Acute and community service reconfiguration	286	Finalise April 04
Trent	Southern Derbyshire	Acute reconfiguration	157	Finalise May 02
Trent	King's Mill Centre	Reshape acute services	66	Finalise Aug 03
<b>Trent total</b>			<b>509</b>	
<b>Grand Total (£m)</b>			<b>3,659</b>	
Plus schemes operational (see above p15) £m			423	
Plus Major schemes under construction (p15)			1,619	
Plus minor schemes (see Appendix 3) £m			735	
<b>Total current &amp; pending PFI projects (£m)</b>			<b>6,419</b>	

Data from PFI Schemes by Region, (DoH website <http://www.doh.gov.uk/pfi/index.htm>).  
 Calculations by John Lister, LHE, multiplying unitary payment by length of contract (or by “?30” years where no length stipulated).