A Review of the Implementation of Private Finance Initiatives in UK Hospitals

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Abstract: Since their inception in 1992, Private Finance Initiatives (PFIs) have become the dominant mode of procurement for UK National Health Service (NHS) hospitals. The private sector initially finances new initiatives which are then repaid through unitary service charges. Despite a great deal of rhetoric around the promise and potential of this funding mechanism, more recently PFIs have been criticized for bringing some NHS trusts to the brink of bankruptcy. Moving forward, assessing whether PFIs can achieve their intended purpose; the provision of more sustainable and affordable solutions, is critical in determining their future usefulness. The purpose of this paper is to identify past and current benefits of the PFI, and evaluate post implementation problems. Our results suggest reduced labour costs and greater productivity are paramount, as is sharing risk. However, in measuring whether PFIs have delivered these benefits there has been a dearth of quantitative performance measurement. Additionally little research has concentrated on critical analysis and performance of PFIs, hampering attempts to evaluate the affordability and sustainability of this solution.

Keywords: Private Finance Initiatives, National Health Service, Hospitals, United Kingdom, Sustainability

Introduction

The United Kingdom launched Private Finance Initiatives (PFIs) to motivate private sector participation in public services, with the specific purpose of reducing the public financing of welfare, a costly part of the public sector (Pollock, 1995; Aldred, 2008a). PFIs were to supplant National Health Service (NHS) expenditures for services that depended on user charges such as car parking, and were subsequently extended to include competitive service opportunities such as inpatient catering and laundry services (Pollock, 1995; Bach and Givan, 2010). The government has extended PFIs further to include capital ventures, leasing of equipment, and clinical services purchasing such as radiology (Pollock, 1995; Aldred, 2008a); suggesting the role of PFIs in NHS has evolved. At inception, benefits associated with PFIs were many and varied. Most notably, adopting PFIs offered a solution that buffered the NHS from increasing capital and maintenance costs; estimated at £4 billion (between 1994 and 1995) (Pollock, 1995). Cost saving created by private investments included downsized labour costs and greater productivity (Grimshaw et al, 2002; Acerete et al, 2011). Surprisingly, little research demonstrates that these benefits were realized in practice.

Perceived Benefits of PFIs

From a public sector perspective, sharing risks afforded by hospital construction is a fundamental benefit (Pollock, 1995; Akintoye and Chinyio, 2005), with risk transfers

justifying health care Public-Private Partnerships (PPP) by enabling costly schemes to appear competitive (Aldred, 2008a). Reducing operating costs and allowing projects to remain off public authorities' balance sheets were two outcomes of transferring risk to the private sector (Kirk and Wall, 2001). Such transfers move risk to organisations better able to absorb and manage it because an increased number of stakeholder share the risk of failure in comparison to a single trust bearing it alone (Aldred, 2008b). Research suggests a consortium's financial partners predominantly bear the risk of PFIs (Asenova and Beck, 2003), but the balance of risk and its implications are discussed very infrequently in the literature. In an age defined increasingly by risk and risk management, it is imperative to consider diverting responsibility to private sector partners, especially at the beginning of the new century when unprecedented public-spending cutbacks have ensured the public sector has experienced difficulties borrowing the large amounts required to construct new hospitals (Yescombe, 2007). Macro-economically, governments keen to alleviate encumbrances that exert pressures on the budgets of public capital, tend to view PFIs favourably (Dewulf et al, 2012).

PFIs promise several benefits to investors in the private sector; investors profit from sustainable long-term income that is underwritten by cash flows backed by the government. Typically, this income is both stable and secure in contrast to revenue gained from organisations operating in the private sector (Aldred, 2008a). Initially, shareholders expected to realize up to 25% on annual returns (Gaffney et al, 1999), but little evidence appears in the literature to ascertain whether such returns were realized. As with many PFI discussions, the brief nature of the policy presents significant evaluation problems; making it difficult to measure both returns and the successes or failures offered by PFIs.

Problems with PFIs

From a public sector perspective, PFIs may represent both expensive borrowing and significant risk financially (Pollock, 1995). Even though the private sector bears the initial costs, unitary service charges - levied annually - repay the debt within a specified period (Aldred, 2008a). Research suggests this arrangement harms public sector operators in the longer term. The original design of PFIs meant subsequent land-value fluctuations resulted in the loss of significant capital by NHS through ceding sites to investors , with the absence of clear strategy to recover property profits in the future (Pollock, 1995). Late descriptions of PFIs suggest the public sector would take ownership of most buildings by the end of the contract (Aldred, 2008a), but many trusts continue to face disadvantages in land-sale values, in having to sell land to fund new projects (Cuthbert and Cuthbert, 2010). Hidden costs also exist. Some organizations in the public sector added bureaucracy to manage PFIs, which increased the cost of operations, and caused private sector organisations to incur higher charges (Acerete et al, 2011). Over a contract's life, private owners might increase yearly charges that were established earlier with NHS or otherwise reduce services (Aldred, 2008a). In either case, unforeseen stakeholders can exert power over NHS, by relinquishing control to organizations in the private sector.

Sub-optimum outcomes are a real danger when varying ideological perspectives in a consortium of organisations undermine goals such as the allocation of risk (Akintoye and Chinyio, 2005). Research suggests health care managers perceive that PFIs led to adversarial relationships between public and private organisations (Aldred, 2008a), due to disparate collaborator agendas (Barlow and Koberle-Gaiser, 2009). Hence, examining how public and private sector players' disparate agendas influence stakeholders - the people and entities to whom both parties are accountable - is essential (Barlow and Koberle-Gaiser, 2009). Although the public sector must consider public and taxpayers' opinions (i.e. the drivers of government cycles), the private sector is accountable to its shareholders (i.e. drivers of profit). This disparity between the drivers of government and profit creates discord; a source of

conjecture for PFIs' long-term usefulness in contemporary liberal democracies (Yescombe, 2007).

Aside from disparate agendas, problems associated with contract design cannot be overlooked. PFI contracts are inherently complicated, making it difficult for public-sector managers to understand them, particularly concerning legal Public Private Partnership (PPP) ramifications (Aldred, 2008a). Although the purpose of a PPP is largely to transfer risk to the private sector, the suggested misallocation and ambiguity regarding risk-distribution in early PFI contracts suggests too much emphasis was placed on quantitative risk management, with more qualitative risks issues largely ignored (Acerete et al, 2011). There are other issues related to contract lock-in and the fast pace of the evolving healthcare landscape. To date, there have been no early PFI contract terminations in the United Kingdom, though terminations have occurred elsewhere (e.g. Australia) at the cost of significant financial interventions. These terminations escalated to a point where PFIs were precluded from meeting service levels proposed in the contract (Acerete et al, 2011). It is prudent to consider the distinction between terms agreed on at the beginning of negotiations, and myriad unforeseen changes likely to occur once a partnership moves into operational stages (Dewulf et al, 2012).

Complexities arising from PFI arrangements introduce obstacles for health care employees who work below managerial positions. For example, PFIs have been reported as reducing employment in non-clinical positions, though this finding is seemingly based on out-of-date data, with employment decline perhaps affected by other factors, such as the current global downturn (Bach and Givan, 2010). However, fear of job losses is a common feature among anti-PFI staekholders, a view tied largely to mistrust of reform management and evolving work arrangements (Dewulf et al, 2012).

Regardless of whether health care workers' worries are valid, a major issue lies in how to measure performance quantitatively. For sustainability, PFIs should offer better value for money (VFM), implementing improved risk management than that offered by other models with VFM considered is an essential method of judging economic and logistic successes of PPP procurement. (Akintoye and Chinyio, 2005). Although much of the literature identifies PFI issues, instead of quantitatively assessing performance, most studies in the PFI literature focus on characterising endeavours.

The National Audit Office (NAO) evaluates VFM offered by PFIs for the United Kingdom as part of its auditing charter. Designed for evaluating projects at proposal and development stages, its primary matrix of analysis covers four criteria: (1) clear project objectives, (2) properly applied processes, (3) selection of best available deals, and (4) judgments that deals makes sense. The matrix originally did not evaluate VFM once a project reached the operational stage, so NAO redesigned the framework to be applicable at any of six earlier stages (NAO, 2005, 6-7). However, traditionally VFM considers financial costs across an entire project, with both the NAO's method and selection of representative measures highly debated (Shaoul, 2005).

Other studies, such as the results of a United Kingdom PFI project review initiated by the Office of Government Commerce remain unavailable to the public (Acerete et al, 2011), with internal cost benchmarking during post-implementation phases remaining absent, severely limiting methods available to evaluate PPP procurement, except for qualitative characterisations and descriptions. In a formative study of PFI performance, Froud and Shaoul (2001) examine the topic in light of both NHS and hospital building and operations, and address five topics regarding performance of contractual initiatives. They survey determination of information quality pertaining to bidding, validation of best alternatives, transfer of risk, public sector comparator relevance and accuracy, and VFM affordability. They suggest the most salient component is that VFM fluctuates innately, especially

concerning long-term agreements. This last finding is crucial because VFM variability suggest different methods may be needed to evaluate the last two decades of PFI contracts.

Conclusions

In these days of increasingly evidenced based policy and practice, the evidence for PFI appears woefully inadequate. Literature suggests PFIs were initially associated with expected benefits such as improved efficiency and cost savings, but other opponents suggest PFIs correlate with greater expenditures, pointing out disparate health care agendas from the public and private sector. We need more than people suggesting advantages and disadvantages of using PPP in health care, with the scale of current expenditure, and in the current financial climate where saving are required in all areas of health care provision, more work is urgently needed that analyses PFI performance critically, evaluating whether this solution really does offer a cost effective and sustainable solution to the growing demand of society.

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Conflict of Interest

All authors declare that they have no conflict of interest.

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