

The Centre for  
International  
Public Health Policy



# Private finance, public deficits

*A report on the cost of PFI and its impact on health  
services in England*

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## Glossary of terms

**Affordability gap** The difference between the price being charged by the private sector and what the NHS trust can afford to pay.

**Availability charge** The portion of the unitary payment related to availability of the hospital to the NHS trust. This is analogous to the 'rent' charged by the private sector for use of a PFI building.

**Capital charge** The sum of the dividend on *public dividend capital* and *depreciation*.

**Capital costs** The sum the *public dividend capital*, *depreciation* and, for trusts with PFI contracts in operation, the PFI *availability charge*.

**Capital expenditure** Money spent on the provision of buildings or equipment.

**Capital value** The public sector's estimate of the value of the property that the private sector provides under a PFI contract.

**Deficit** The public sector equivalent of a loss. A deficit in a public body's Income and Expenditure account means that the organisation has spent more than it has earned during the year.

**Depreciation** This reflects the consumption or usage of an asset in a year by including an allowance in expenses for this usage.

**Income** The income balance in the Income and Expenditure account shows the value of what the organisation has earned in the year. In the case of an NHS trust, income is largely earned for the provision of healthcare services through the *tariff*.

**Interest** An amount that a bank charges on a commercial loan over and above its own cost of providing the loan.

**'Hard' facilities management services** The maintenance of buildings and equipment. These are distinct from *'soft' facilities management services*, and are always included within the scope of PFI contracts in the NHS.

**NHS Foundation Trust** Subject to different financial controls to the rest of the NHS, these organisations are authorised and regulated by an independent regulator, Monitor.

**NHS trust** A public sector organisation which provides hospital and other acute healthcare services to NHS patients.

**Nominal terms** Values expressed in nominal terms are actual values and include actual or projected price changes due to inflation. The term is used to contrast with 'real terms'.

**Operational** A PFI contract is operational when the building works are completed, the facility is made available to an NHS trust, services are being delivered and *unitary charges* are being paid.

**Outline Business Case** A detailed document drawn up by a public body for the purpose of securing government approval for a given investment proposal. These include planning assumptions, revenue costs and an analysis of the options available to deliver the objectives of the investment.

**Payment by Results** A system in which *Primary Care Trusts* fund NHS trusts according to a centrally-determined tariff for each actual activity undertaken, designed to reflect the average costs of providing that activity among service providers.

**Private Finance Initiative** A policy introduced by the British Conservative government in 1992. In the NHS, this involves the private sector designing, building and financing new hospitals, and providing non-clinical services within them once completed.

**Public dividend capital (PDC)** This represents the money invested by the Treasury in the NHS trust when it was originally established. The Treasury receives a return on this 'investment' each year (a dividend), which is paid from the trust's budget.

**Primary Care Trust (PCT)** A local public body which receives taxpayers money and uses this to commission healthcare services from organisations including NHS trusts.

**Re-configuration** A change in how healthcare services are provided within a given locality, with particular respect to the split in provision between different types of care (e.g. acute, community, primary etc).

**Service charge** The portion of the unitary payment which is related to the non-clinical services provided to the NHS trust by private sector contractors under a PFI contract.

**'Soft' facilities management services** Non-clinical services provided in hospitals such as catering, cleaning, security, providing porters and help-desk support. These are distinct from '*hard facilities management services*' and are often excluded within the scope of the PFI contract.

**Strategic Health Authority** England's 28 strategic health authorities have a strategic role in managing the local NHS on behalf of the Secretary of State. They are responsible for ensuring that national priorities are integrated into local health service plans.

**Tariff** The rate at which hospitals are reimbursed for their activity by local Primary Care Trusts and other commissioners, based on 'reference costs' designed to reflect average NHS costs.

**Unitary charge** The annual payment due from the NHS to its private partner in respect of the provision and operation of a PFI contract.

## **Executive Summary**

Since 1992 the British government has favoured paying for capital works through the private finance initiative (PFI) - that is, through loans raised by the private sector. For hospitals this means that a private consortium designs, builds, finances, and operates new hospitals. In return the NHS trust pays an annual fee to cover the capital cost, including the cost of borrowing, and any non-clinical services that the private sector provides over the 30-60 year contract period.

The policy has been controversial because of the high costs and association with cuts in clinical services. Despite this, the PFI programme in England's NHS is being expanded. As of April 2007, there were 85 signed PFI contracts in the Health Service, with a combined capital value of £8.5 billion. Under current plans, the Department of Health will procure a further 41 schemes, bringing the total capital value of PFI schemes to £15.5 billion.

In 2005/06, the NHS made PFI payments of £470 million to PFI consortia. But as the PFI programme expands, these annual commitments will increase. By 2013/14, when all 126 schemes in the current programme are in operation, PFI payments will be £2.3 billion a year.

In total, the amount of money to be repaid by NHS trusts will almost double, from around £50 billion in 2005/06, to more than £90 billion by 2013/14.

The existing PFI schemes are a source of financial difficulty for NHS trusts. Prior to contracts being signed, NHS trusts prepare business cases which purport to show that their PFI plans are 'affordable' within projected budgets. Since PFI costs are higher than historical capital costs, all business cases contain plans to sell assets and cut service capacity to offset the shortfall.

This report shows that these cuts have been insufficient to bridge the funding shortfall. The cost of PFI contracts for most trusts is greater than the capital they are provided with through the NHS resource allocation mechanism. Crucially this under-funding has led to the emergence of financial deficits, and, under government pressure to balance the books, plans for further cuts to services.

Under Payment by Results, trusts receive most of their income through a standard tariff for treatments, which includes an element for capital costs based on 5.8% of trust income. However, the capital costs of trusts with PFI schemes average 8.3%, with the result that they are under-funded.

The problem is even more serious for trusts with large or multiple schemes. Trusts with operational PFI schemes with capital values of over £50 million have average capital costs of 10.2% - a shortfall in income of 4.4%. This under-funding has created serious financial difficulties for many trusts, which can only be reconciled by further service reductions.

In South East London, for example, local health officials have highlighted PFI costs as the main contributor to deficits among the area's trusts. In particular, Bromley and the Queen Elizabeth Hospital trusts, which have 'whole hospital' PFIs in operation, are significantly under-funded for their PFI costs.

This led to aggregate debts of £180 million by the end of 2006/07. Because of the high cost and intractable nature of PFI contracts, local health officials are considering focusing cuts on trusts with cheaper public, rather than expensive PFI assets.

While PFI appears to be a major cause of deficits and associated service cuts among trusts, its inflexible nature means that plans for reductions to service capacity are affecting health economies more widely.

**This report is in three sections.**

**Section 1** outlines the scale, structure and operation of the private finance initiative in England's NHS.

**Section 2** examines the public expenditure implications of the current and future PFI contracts.

**Section 3** investigates the association between PFI, the national tariff and the financial problems facing NHS trusts.

# Section 1: The scale, structure and operation of PFI in England's NHS

## 1.1 The importance of PFI

Since 1992, most large-scale capital investment in the NHS has come through the private finance initiative (PFI), where funding for projects is raised on the financial markets by groups of investment banks, builders and service contractors.

These consortia design, build, finance and own the new health facilities, and provide 'facilities management' services upon completion.

This approach differs from the conventional public procurement model in which a public authority engages an architect to design new facilities and a construction contractor to build them. Under this approach, capital works are financed directly by central government, with money raised through taxation and/or the issuing of Treasury gilts. The building is owned and operated by the public sector.

The government signed the first hospital PFI contract in July 1997 and the first PFI hospitals were delivered in autumn 2000. Between April 1997 and April 2007, the majority of contracts for new hospital projects – 85 out of 110, or some 87.3% – came through PFI. The method accounted for 87.4% - £8.5 billion out of a total of £9.7 billion - of the capital investment in the hospital building programme.<sup>1</sup>

As of April 2007, the Department of Health had approved 126 PFI projects for England's NHS, bringing the total capital value to £15.5 billion. Of these, 85 have been signed with private sector consortia, at a capital value of £8.5 billion<sup>1</sup>. A

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<sup>1</sup> Department of Health, 'Progress of new hospital schemes approved to go ahead'. Available at: [www.dh.gov.uk](http://www.dh.gov.uk) (accessed April 2007).

further 41 PFI hospital schemes with a total capital value of £7 billion have been approved, and are at the planning stage or are being procured.

## **1.2. Financing new investment**

Hospitals built under the PFI are leased by NHS trusts from the private sector for periods of 30 to 60 years. The NHS trust pays the contractor an annual fee for the duration of the contract from the day the hospital opens, at which point the PFI contract becomes 'operational'. The money to pay the fee comes from the NHS trust's own budget, which is also used for clinical services, staff and supplies.

## **1.3. The annual PFI unitary charge**

In the NHS, PFI contracts combine two types of transaction: the provision of *assets* such as buildings and equipment; and the provision of *services* such as buildings maintenance, cleaning and catering. The payment for the provision of assets is called the *availability charge*; the payment for the provision of services is called the *service charge*. Together, these are known as the *unitary charge*.

### *i. The annual availability charge*

The availability charge is a fixed cost which varies only if new requirements outside the terms of the contract arise, or if the consortium is penalised for failing to meet performance standards. The charge covers three types of cost.

First, it funds interest and principal payments on the debt taken out by the PFI consortium. This claim takes precedence over all others, and accounts for a significant proportion of the availability payment. The lending institutions have an interest in ensuring that this payment stream is clearly identifiable and protected, and PFI financial models are structured accordingly.

Second, the consortium has to build up cash reserves in order to meet “lifecycle” costs - expenditure that may be required during the contract in order to maintain the condition of the facilities.

Finally, once these costs have been met, the availability payment funds return to shareholders in the form of dividends. Under normal private financing arrangements (which are subject to change if schemes are refinanced), an increasing proportion of the availability payment provides profit to the PFI consortium’s shareholders as debt is paid off over the contract period.

#### *ii. The annual service charge*

The range and specification of services delivered under PFI will vary from project to project. All PFI contracts include the contracting out to the PFI provider of so-called ‘hard’ facilities management services, such as routine building maintenance work. The majority of NHS PFI contracts also involve the outsourcing of ‘soft’ services, such as catering, cleaning, security, helpdesk support and portering.

Prior to June 2001, members of staff involved in PFI contracts were transferred to private sector employment under TUPE regulations, and many subsequently received less favourable terms and conditions. Since June 2001, however, most facilities management staff involved in PFI agreements have transferred under secondment arrangements, and have thereby retained their NHS employment.<sup>2</sup>

#### **1.4. Meeting the annual unitary charge**

Most trust income is spent on the labour and supplies it needs to deliver clinical services. Since 1992, however, each trust has had to devote a share of its income to paying *capital charges* to the Treasury for the use of land, buildings and equipment. Under the current regime, trusts are obliged to operate in such a way

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<sup>2</sup> Unison (2003), ‘The Private Finance Initiative: The Retention of Employment Model’, Unison, London

as to produce annual surpluses equivalent to 3.5% of the current value of their existing assets, i.e. buildings, land, and equipment (down from 6% previously). In addition to paying this, the *dividend on public dividend capital*, they must also pay for the *depreciation* of their assets.

Currently, when a trust signs a PFI contract for a hospital and transfers the assets of the hospital to the private sector (as is usually the case) it is no longer obliged to pay capital charges on the land and property transferred. In theory, this releases funds out of which the trust can pay the PFI availability charge, while the fee for privately delivered facilities management services is paid from the budget previously allocated to in-house provision.

The capital charge and the availability charge can each be thought of as the ‘rent’ the trust pays for the use of its hospital buildings and equipment – that is, its capital costs. However, it is important to note that, while capital charges revert to the Treasury, the availability charge is paid to the PFI consortium and is money lost to the NHS and the taxpayer.

### **1.5 Private finance and the affordability gap**

The private finance initiative has long been controversial because of its high cost, which leads to an affordability gap for NHS trusts.<sup>3,4,5,6</sup> In practice, the cost of PFI has been higher than the cost of the capital charge. As a consequence, prior to projects being signed, trusts make an attempt to close the affordability gap through plans to divert funds from clinical budgets, selling assets and significantly reducing bed capacity and staff in hospitals and other services.<sup>4,5</sup>

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<sup>3</sup> Gaffney D, Pollock AM, Price D, Shaoul J. NHS capital expenditure and the private finance initiative: expansion or contraction? *BMJ* 1999;319:48-51.

<sup>4</sup> Gaffney D, Pollock AM, Price D, Shaoul J. PFI in the NHS: is there an economic case? *BMJ* 1999;319:116-9.

<sup>5</sup> Hawksworth J. Implications of the public sector financial control framework for PPPs. In: *The private finance initiative: saviour, villain or irrelevance?* London: Institute of Public Policy Research, 2000.

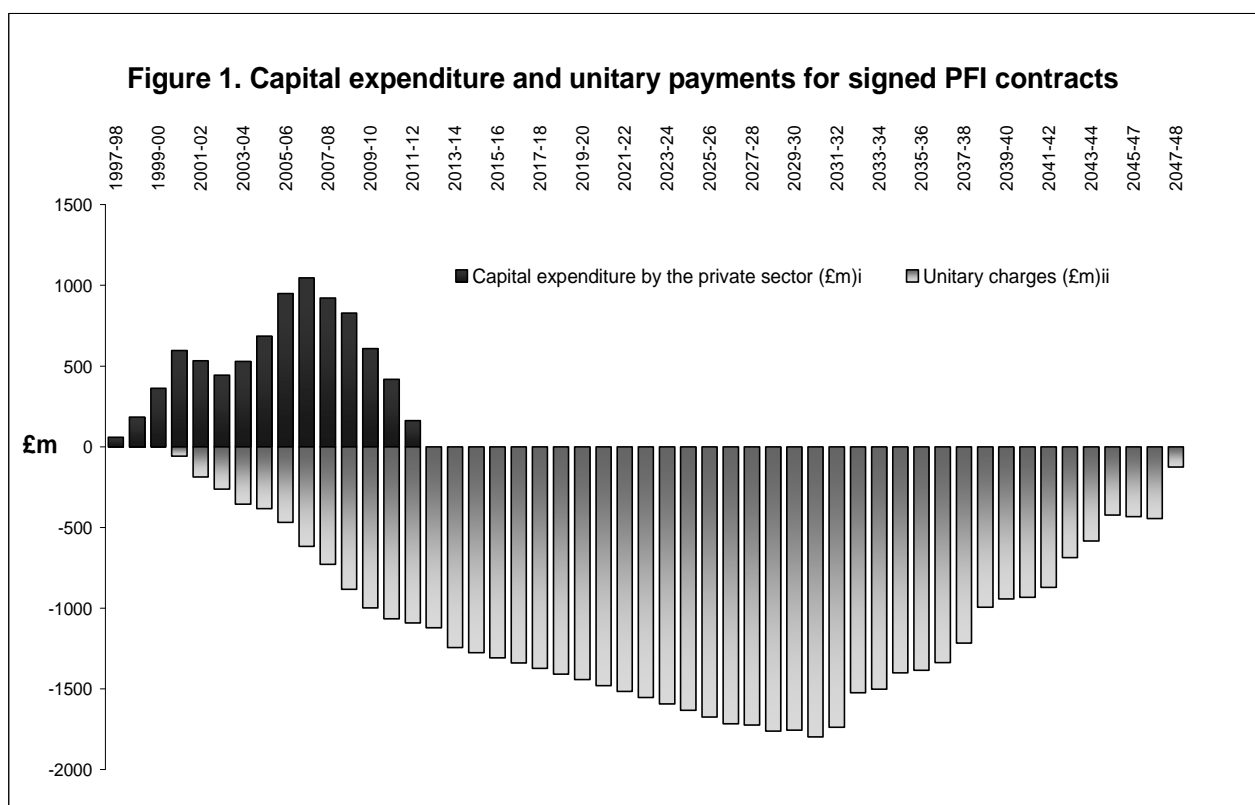
<sup>6</sup> Heald D, Scott D. Lessons from capital charging in the UK national health service. *Int Assoc Management J* 1996;8:29-45.

In this context, Section 2 of this report examines the public expenditure implications of current and future PFI projects. Section 3 examines the financial challenges posed by PFI during the operational phase of a PFI project, after contracts are signed and attempts have been made to bridge the affordability gap.

## Section 2: PFI and public expenditure

### 2.1. Comparing PFI investment with projected PFI payments

The Department of Health does not publish data on the public expenditure implications of PFI schemes for the NHS. However, using data acquired from a Freedom of Information request to the Departments of Health, we obtained data on actual and projected annual unitary charges for all PFI contracts signed by 30 November 2006, and compared these with publicly available information on the capital investment raised by private consortia for all schemes.



<sup>i</sup> Department of Health. Public Expenditure Memorandum: 2005-2006. 26 October 2006. The Stationary Office. London. pp. 35-43

<sup>ii</sup> Freedom of Information response from Department of Health, 30 November 2006.

As Figure 1 shows, the upfront capital expenditure relating to PFI schemes signed as of 30 November 2006 was £8.3 billion<sup>7</sup>, whereas NHS spending commitments

<sup>7</sup> The difference between this figure and that used in the rest of the paper (£8.5 billion) is due to the less recent date. Note the £8.3 billion figure is for *capital expenditure*, as opposed to *value* (see *Glossary*).

amount to more than £52 billion.<sup>8</sup> Payments to be made by the NHS will therefore be around six times greater than the upfront capital cost to the private sector.

It should be noted, however, that a portion of the projected NHS expenditure relates to payment for services, and that this should be regarded separately from the availability charge. The point is considered below.

## **2.2 Estimating the availability charge**

The Department of Health could not provide an exact breakdown of the unitary charge into its availability and service charge components on the grounds that it no longer collects this information centrally.

However, Department of Health research<sup>9</sup> shows that, on average, the availability charge accounts for 58.7% of the cost, and facilities management 41.3%. We rounded these figures to 60% and 40% respectively and applied them to the actual and projected unitary charges to estimate the availability and facilities management components. On this basis, the total availability charge is £31 billion over the contract period, compared with £8.3 billion raised by private consortia.

For many schemes, this is an underestimate of the availability charge element. In the Department of Health's sample of 25 PFI schemes, 23 included 'soft' facilities management services within the contract. It has subsequently become much more common for soft services to be excluded from deals. Where soft services are not included in deals, the availability charge component of the unitary charge will obviously be much greater relative to the facilities management element.

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<sup>8</sup> This figure is in nominal terms. Real payments will therefore vary as a result of changes to RPI. In addition, unitary payments may fluctuate as a result of adjustments made relating to the performance of the contractor, additional services requested by the trust and the effect of refinancing.

<sup>9</sup> Department of Health (2000), Public Expenditure Memorandum: 1999-2000 (The Stationary Office, London). pp.152-158

Schemes which exclude soft services are therefore marked with an asterisk in Table 1, 2 and 3 in the Appendix. For these schemes, the real figure for availability charges is likely to be greater than the estimate.

### **2.3. The current cost of operational PFI schemes**

Using publicly available data from the Department of Health and data provided under a Freedom of Information response, we examined the capital value of the 53 PFI schemes that were accruing charges in 2005/06 (the latest year for which actual, rather than estimated, figures are available) and the availability element of this charge.

In total, annual PFI expenditure for NHS trusts making PFI payments in 2005/06 was £470 million, of which £280 million is the availability charge.

### **2.4. The future costs of PFI in the NHS**

The scale of the cost to the NHS is to grow significantly as more schemes become operational and PFI payments begin.

Using publicly available data from the Department of Health and data provided under a Freedom of Information response, Table 2 shows the estimated costs of PFI in the NHS for the year 2013/14, when all 126 PFI schemes that are currently approved are likely to be operational and accruing unitary charges.

Table 2 provides a summary of capital values and estimated unitary charges in 2013-14 for (a) 53 schemes in operation and accruing charges from 2005/06; (b) 32 schemes signed and in construction, or recently become operational; and (c) 41 schemes in procurement or planning. (More detailed tables showing these data for each NHS trust are provided in Tables 3, 4 and 5 in the Appendix).

**Table 2. Capital values and annual unitary payments for projects in 2013/14**

	Capital value (£m) <sup>10</sup>	Annual unitary charges (£m)
a. Schemes in operation from 2005/06 ( <i>n</i> =53)	2,792	599.5 <sup>11</sup>
b. Schemes currently signed and in construction (or operational 2006-07) ( <i>n</i> =32)	5,659	650.5 <sup>12</sup>
c. Schemes in procurement or planning ( <i>n</i> =41)	7,042	1,042 <sup>13</sup>
<b>Total by 2013/14</b> ( <i>n</i> =126)	<b>15,493</b>	<b>2,292</b>

For the 53 schemes that were operational and accruing charges in 2005/06, annual unitary payments will increase from £470 million in 2005/06 to almost £600 million in 2013/14, largely due to inflation. The availability component increases from £280 million to £360 million.

For the 32 schemes in construction or those that are operational but were not yet accruing charges in 2005/06, total unitary charges will be £650 million in 2013-14, of which £390 million is the availability charge.

The combined capital value of the 41 schemes that are in procurement or planning (£7 billion) is set to almost equal the capital value of all schemes currently in operation or in construction (£8.5 billion). This demonstrates the scale of the expansion of the PFI hospital-building programme in England. By 2013-14 when

<sup>10</sup> Department of Health, 'Progress of new hospital schemes approved to go ahead'. Available at: [www.dh.gov.uk](http://www.dh.gov.uk) (accessed April 2007).

<sup>11</sup> Department of Health, response to Freedom of Information request, received 30<sup>th</sup> November 2006. Note that the increase from the figure for unitary charges in Table 1 is due to the application of an estimated rate of inflation, since PFI payments increase year-on-year according to changes in RPI.

<sup>12</sup> Department of Health, response to Freedom of Information request, received 30<sup>th</sup> November 2006.

<sup>13</sup> These estimates are based on the average unitary charge-to-capital value ratio for schemes in operation or signed and in construction (that is, 14.8%). The estimate is necessarily a rough one, since unitary payments vary over time and the scope of each project (in terms of which services are included) has often not been decided for schemes in procurement or planning.

the number of schemes accruing charges grows from 53 to 126, the annual cost of PFI to the NHS will increase more than four-fold from 2005/06.

By 2013-14, NHS trusts in England will be paying annual charges totalling £2.3 billion (in nominal terms), an increase of more than £1.8 billion on that paid in 2005/06. On a conservative estimate, the availability charge component of this will be £1.4 billion per annum.

The future expenditure commitments for all current and future NHS PFI schemes will increase from £52 billion as of November 2006, to £90 billion.

## **2.5 Caveats to estimates**

It is important to note that, for future schemes, figures for capital values, unitary charges and availability charges are likely to be significant underestimates, for two reasons.

### *i. Post-contractual increases in unitary costs*

In addition to the effect of inflation, unitary charges tend to be higher than those contained in PFI business cases and agreed at the point at which contracts are signed (the basis of the government's projections). Shaoul et al<sup>14</sup> show that 10 out of their sample of 12 trusts with operational PFI schemes were paying more than anticipated at when contracts were signed.

The scale of the increases has in some cases been very large. In 2005, seven trusts were paying more than 10% more than expected at contract signing; three were paying in excess of 50% more. In interviews with the trusts, managers explained that these increases stemmed from a number of sources, including: increases in the hospitals' throughput over that set out in the contracts, contract changes and

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<sup>14</sup> Shaoul, J., Stafford, A., Stapleton, P. (forthcoming), 'The cost of using private finance to build, finance and operate the first 12 NHS hospitals in England'. *Public Money and Management*. London.

unanticipated increases due to failure to identify and/or specify requirements in sufficient detail in the contract.

As Shaoul *et al* note, all changes to the contract will be made in conditions of monopoly provision, presenting a clear risk that contractors will charge higher prices than would be possible in competitive circumstances.

*ii. Increases to costs during procurement*

A second issue is the well-established tendency for the capital value, unitary and availability charges to increase considerably during negotiations with the private sector. This tendency was observed by the Audit Commission in a recent study of NHS deficits.<sup>15</sup>

The Commission commented:

“The attraction of the big building project, both to local NHS management and across the wider community, makes it difficult to withdraw from negotiations or reshape the vision once strategic approval has been gained and detailed discussions are underway. This carries a clear risk of commitment to spending levels based on optimistic future income assumptions, ambitious savings arising from improved operational efficiency, or both (p.28).

Table 6 in the Appendix compares the capital values of ‘prioritised’ PFI schemes – those schemes that have been prioritised by the Department of Health because of their size and importance<sup>16</sup> - recorded at the Outline Business Case stage (when project plans are initially approved by the Department of Health) with values at the time contracts were signed. The average increase between OBC and contract signing is 74% (in real terms, this figure will be lower).

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<sup>15</sup> Audit Commission, ‘Learning the Lessons from Financial Failure in the NHS’, pp.27 July 2006, London.

<sup>16</sup> These projects tend to be large ‘whole hospital’ procurements, as opposed to smaller scale investments. They were ‘prioritised’ by the Labour government due to their size and importance.

## Section 3: PFI, resource allocation, deficits and service cuts

### 3.1. Payment by Results

This section examines the relationship between PFI, trust deficits and the new system of resource allocation for England's NHS called Payment by Results (PbR). Under PbR, trusts receive the bulk of their income through a standard tariff for each patient that receives treatment.

The tariff is based on the average cost of providing the treatment across the NHS,<sup>17</sup> and includes funds for capital costs (i.e. the dividend on public dividend capital, depreciation and, where applicable, the PFI availability charge), designed to equal to the average capital cost across all English trusts. Currently, this is 5.8% of each trust's annual income from activities.

Under PbR, trusts that have higher than average capital costs will tend to incur a deficit on their income-expenditure accounts.<sup>18</sup> In contrast, trusts with lower than average capital costs will tend to be in surplus. This section examines the capital costs of trusts with PFI schemes, comparing these costs with the average.

In Table 7 (appendix) we show the share of income that Trusts devote to capital each year. This includes the PFI availability charge, the capital charges paid on NHS equipment and estate (public dividend capital) and depreciation.

Data on trusts' capital costs and total incomes were provided by the Department of Health under a Freedom of Information response. Using these data, we calculated for each trust the annual cost of capital by aggregating public dividend capital,

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<sup>17</sup> Department of Health, Payment by Results Guidance, Version 1, December 2006. Available at: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_063684](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063684)

<sup>18</sup> Further explanation of this point is given in Palmer K (2006), 'NHS Reform: getting back on track', King's Fund Discussion Paper.

depreciation and the availability charge in 2005/06, and the annual cost of capital to the trusts as a percentage of trusts' income.

Almost all NHS trusts (foundation trusts are excluded) with operational PFI schemes had capital costs in excess of what was provided under the tariff. On average, trusts with PFI schemes that were operational and incurring charges in 2005/06 had capital costs of 8.3% that year – 2.5% higher than the average (see Table 7 in the appendix for the trust-specific data).

This means that trusts with one or more PFI schemes in operation that year, are, under the tariff, under-funded for their capital costs by some 2.5% of income and are therefore vulnerable to going into deficit<sup>19</sup>.

However, it should be noted that many of the 53 PFI schemes that were operational in 2005/06 are small in capital value terms, and their impact on trust expenditure is correspondingly minor. The extent of this problem is greater for trusts with larger schemes.

For the 18 trusts that were, in 2005/06, paying charges on schemes with a capital value of over £50 million, average annual capital costs were 10.2% of total income in 2005/06, compared with 5.8% in the tariff. In other words, these trusts experience an average shortfall in income of 4.4% (see Appendix, table 8, for trust-specific data).

Even among trusts with large PFI schemes there is considerable variation, (see Figure 2, overleaf). Capital costs at the former County Durham & Darlington Priority NHS trust (now incorporated in the Tees, Esk and Wear Valley NHS trust)

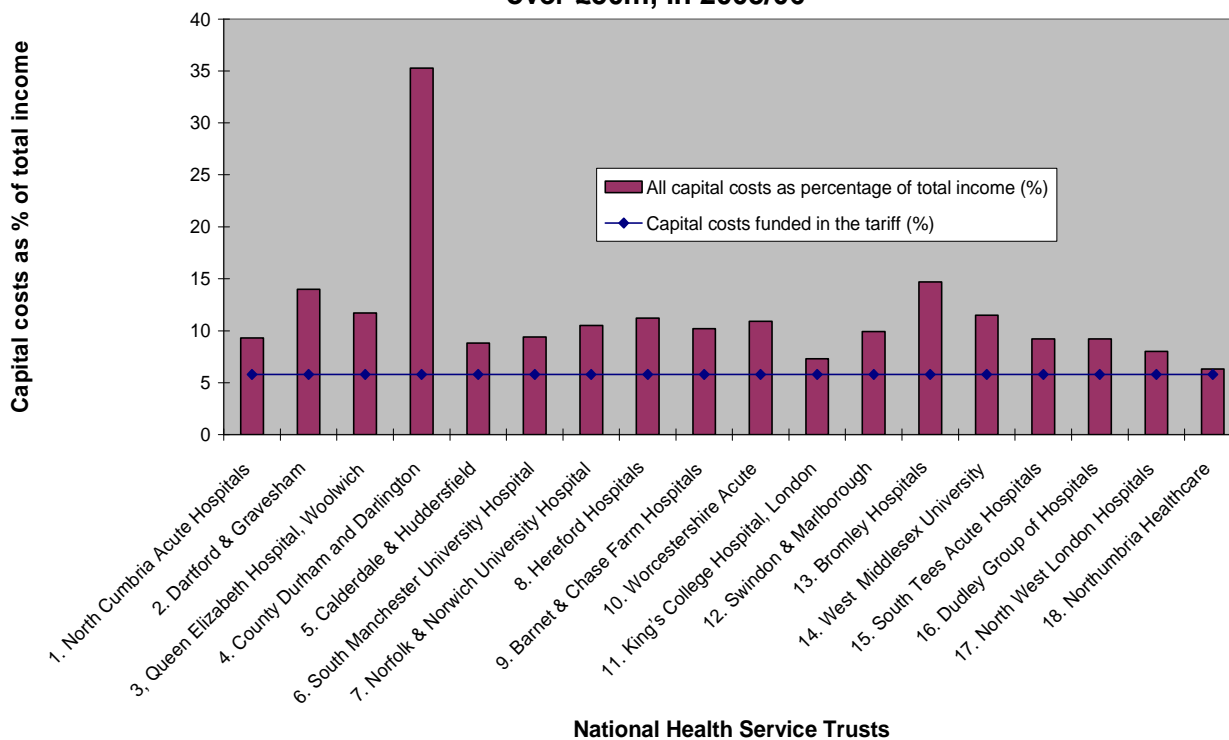
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<sup>19</sup> The concept of 'excess' capital costs was developed by Keith Palmer in a number of publications, in print and forthcoming. See particularly, Cambridge Economic Policy Associates (2007), 'Analysis of the causes of the Queen Elizabeth II Hospital Trust Deficit', CEPA Ltd, London

account for 35% of total income – some 30% higher than the amount funded in the tariff. This contrasts with trusts such as King’s College, London and Calderdale & Huddersfield where capital costs are less than 10% of income.

County Durham & Darlington pay unitary charges on three PFI contracts in 2005/06, whereas King’s College and Calderdale & Huddersfield make payments on just one each. PFI schemes are only a small part of the estates of these two trusts.

**Figure 2 Capital costs for Trusts with PFI schemes with a capital value of over £50m, in 2005/06**



Almost all PFI trusts are experiencing a funding shortfall for the cost of capital, but this is shortfall is greater for all PFI schemes with a capital value of over £50 million.

This analysis explains a widely observed problem: the fact that trusts with large capital projects recently completed seem to encounter financial problems. For

example, the Audit Commission has noted a “marked correlation” between the presence of large new building projects and deficits in the NHS.<sup>20</sup>

The Commission suggested this may be caused by the amount of management time devoted to the process of constructing and moving into new facilities. However, a more obvious explanation for the “marked correlation” between new hospitals (almost all of which have been delivered through PFI since 1997, as outlined in Part 1) and deficits is simply the high cost of these contracts and the under-funding they give rise to.

In a policy context in which ensuring NHS trusts are ‘in the black’ is privileged over the capacity of services to meet local health need, there is clear evidence that these trusts are again diverting resources from expenditure on clinical services to expenditure on facilities and equipment.

### **3.2. The problem of under-funding capital costs**

To illustrate the effect of higher-than-average capital costs, this part of the report examines the case of acute sector deficits in South East London, an area of severe deprivation and high health need, and Worcestershire.

#### *South East London*

This locality is administered by the South London and Maudsley Strategic Health Authority (SHA), which provides support to six NHS trusts which provide acute services. These comprise two teaching hospitals: King’s College and Guys and St Thomas’; and four district general hospitals: University Hospital Lewisham, Queen Elizabeth Hospital in Woolwich, Bromley Hospital and Queen Mary’s Sidcup.

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<sup>20</sup> Audit Commission, ‘Learning the Lessons from Financial Failure in the NHS’, pp.27 July 2006, London.

In a recent paper, the SHA showed that the financial problems relating to South-East London were most severe<sup>21</sup> at Queen Elizabeth and Bromley. These are the only two hospital trusts with large 'whole hospital' PFI schemes in the locality.

In 2005/06, there was a deficit of £66 million across the locality's four district general hospitals, with the largest outflows at the Queen Elizabeth and Bromley. In 2006/7 these trusts recorded a further deficit of £33 million (Queen Elizabeth £13m and Bromley £20m) while the two 'non-PFI' trusts, Lewisham and Queen Mary's, recorded operating surpluses.

By the end of 2006/07, the aggregate debt payable by the four district generals to the SHA had increased to over £180 million, with QEH and Bromley accounting for about 84% of this.

According to the SHA, the deficits of both trusts arise "because the cash costs of the PFI availability charge exceed funding for capital charges in tariffs." In 2006/07, Bromley and QEH had capital cost/income ratios (all capital charges, plus the PFI availability charge) of 11.3% and 10.4%, respectively, against the NHS average of 5.8%. The SHA noted that Lewisham's ratio will rise from 5.3% in 2006/07 to 8.2% when its PFI hospital scheme becomes operational in 2007/08.

This SHA data demonstrates that, whereas the availability costs incurred by Guys and St Thomas', Kings College and Queen Mary's are fully funded in tariffs, Bromley and Queen Elizabeth, with large PFIs, have capital costs that are not wholly funded in the tariffs. Lewisham will incur a similar burden when its scheme becomes operational.

The SHA's paper comments that these trusts will therefore:

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<sup>21</sup> South London and Maudsley Strategic Health Authority (2007), 'Acute Sector deficits in SE London'. London.

“incur recurrent [income/expenditure] and cash flow deficits even if they operate as efficiently as the average hospital trust in England. A high proportion of their underlying [income/expenditure] and cash flow deficits are attributable to this effect” (p.7).

### *The SHA’s plans for eliminating deficits*

It is interesting to note the SHA’s proposals to help address the financial difficulties in South East London. The SHA suggests that achieving “financial balance” in the area cannot be achieved without significantly reducing their “controllable costs” - i.e. their spending on services. The paper states:

“Achieving the [income and expenditure] out-turn planned for 2007/8 will require further substantial reductions in staff costs and staff numbers.” (p.10)

While cut-backs at the affected trusts are likely to occur, the SHA advises that cuts should be focused, where possible, on district general hospitals *without major PFI commitments*.

This is because, the SHA explains, PFI capital and service costs are to a large extent fixed. PFI trusts are unable to sell any surplus estate (because they do not own it), nor may they lease part of their sites to a third party user without the consent of a majority of the bondholders. Achieving such consent would be “difficult to achieve and costly”, the SHA’s paper states (p.22).

Meanwhile, service costs are in effect ring-fenced because “negotiation of revised terms is likely to prove difficult and expensive because [the private provider] has strong existing rights” (p.23). In a context in which cuts must be made, activity will be focused on the trusts with PFI contracts, at the expense of adjacent trusts:

“It will be necessary to reconfigure services in ways that increase the utilisation of capacity at sites where there is little scope to reduce fixed occupation costs [and] reduce activity at sites where

there is relatively greater scope to reduce fixed occupation costs by selling or leasing surplus estate.” (p.26)

Recent proposals for the London NHS, outlined by the Department of Health in a recent paper, *Framework for Action*<sup>22</sup>, envisage a major shift in the pattern of NHS provision away from hospitals and toward community ‘polyclinics’, and a corresponding re-organisation of the NHS estate. Many hospitals are to reduce the scope of their services.

In an interview with *The Guardian*, the newly appointed health minister and *Framework* author, Dr Ara Darzi, claimed PFI contracts would not be a barrier to the reconfiguration process<sup>23</sup>. He reportedly told the newspaper that, if a district general hospital changes its status to become a local or specialist hospital, the cost of PFI unitary charges would stay the same.

However, as the South East London case demonstrates, while the high cost of PFI is often the driver for change, such as the downgrading of services, the inflexibility of contracts acts restricts the extent to which reductions in service capacity can be targeted at the trusts directly involved. Indeed, in many cases, they are likely to increase their activity, at the expense of adjacent trusts.

There are currently 10 operational PFI schemes in London that have a capital value of over £50 million, and a further six are in construction, procurement or the early stages of planning. The process of re-configuring London’s NHS estate is certain to be influenced by the number of PFI schemes in operation in the capital.

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<sup>22</sup> Department of Health, ‘Framework for Action’, Department of Health, London

<sup>23</sup> Carvel, J., (2007), ‘Labour’s NHS Plan: the end of the local general hospital’, 17 July, *The Guardian*, London

### *Worcestershire*

The deficit problem is not restricted to London, however. Worcestershire Acute Hospitals NHS trust overspent by £4.9 million in 2005-06 and recorded a cumulative deficit of £31.8 million<sup>24</sup>. The trust attributed £7 million of this to the costs of the PFI charge in excess of that funded through the tariff.

The trust recorded its plans to reduce staff numbers by 675, and identified the need for what it described as “a comprehensive review of services” in each of its three hospitals (including the downgraded Kidderminster hospital and neighbouring Redditch and Queen Alexandria), amid and “serious questions about their sustainability”. It is not known how neighbouring trusts will be affected by the planned changes.

In general, it appears that the cuts and service closures that were planned prior to contracts being signed in order to make the PFI scheme affordable have still left a funding gap, and further service closures will be necessary.<sup>25</sup> Health ministers have made clear that the re-configuration plans for London are part and parcel of a nationwide change.<sup>26</sup>

The experience of South East London suggests that reductions in clinical capacity will not be limited to PFI trusts, but will also impact on the wider health economy.

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<sup>21</sup> Worcestershire Acute Hospitals NHS Trust, ‘Health Committee Written Evidence’, (not yet published, but available from the clerk of the House of Commons Health Select Committee).

<sup>22</sup> Pollock, AM., Price, D., Dunnigan, M., ‘Deficits before patients: a report on the Worcester Royal Infirmary PFI and Worcestershire Hospital reconfiguration’, June 2000, University College London, London.

<sup>26</sup> Carvel, J., (2007), ‘Labour’s NHS Plan: the end of the local general hospital’, 17 July, The Guardian, London

## 4. Conclusion

In 2005/06 there were 53 operational PFI schemes in the NHS with a capital value of 2.8 billion. Under current government plans, by 2013/14 there will be 126 PFI schemes with a capital cost of 15.5 billion. The annual unitary charge is set to increase from £470 million in 2005/6 to £2.3 billion in 2013/14. Over the same time period, the total PFI expenditure implications over the life of the contracts will increase from £52 billion to £90 billion.

This expansion is occurring despite continued controversy surrounding PFI over its high cost and the association with service cuts and closures.

This report shows that the unfunded costs of trusts with operational PFI contracts remains significant, despite the service cuts made in earlier attempts to bridge the affordability gap. The extent of under-funding increases with the size of the PFI and for many trusts leads to major financial difficulties. Trusts with major schemes are, on average, under-funded by some 4.4% of their total income under Payment by Results.

This under-funding creates pressure for a further wave of cuts in service provision to reduce deficits. In South East London and Worcestershire, NHS officials are acting on these pressures – largely through plans for re-configuration, which are likely to include closures of acute and other services.

In addition, the fixed, intractable and inflexible nature of PFI places a constraint on service cuts for the trusts directly involved in contracts. In this context, trusts with NHS assets are as vulnerable to cuts and services closures as PFI trusts.

## Appendix

**Table 1. Actual unitary and estimated availability payments for projects in 2005/06**

PFI scheme in operation	Capital value (£m) <sup>27</sup>	Unitary charge in 2005/06 (£m) <sup>28</sup>	Availability charge in 2005/06 (est.) (£m)	Availability charge as % of cap. value <sup>29</sup>
1. North Cumbria Acute	67	14.8	8.9	13.3
2. Dartford & Gravesham	94	20	12	12.8
3. Buckinghamshire	45	11.4	6.8	15.1
4. Queen Elizabeth	96	20.6	12.4	12.9
5. Tees Esk & Wear (Durham)	61	13.2	7.9	13
6. Tees Esk & Wear (B. Auck.)	48	9	5.4	11.3
7. Calderdale & Huddersfield	65	18.4	11	16.9
8. South Manchester Univ.	67	21.7	13	19.4
9. Norfolk & Norwich	158	41.7	25	15.8
10. Hereford Hospitals	64	11.7	7	10.9
11. Barnet & Chase Farm	54	15.1	9	16.6
12. Worcestershire Acute	87	22.8	13.7	15.7
13. King's Healthcare	76	18.4	11	14.5
14. Swindon & Marlborough	100	19	11.4	11.4
15. Leeds Comm & Mental HS	47	8.9	5.3	11.3
16. Bromley Hospitals	118	19.6	11.8	10
17. Hull & East Yorkshire*	22	2.1	1.3	5.9
18. Berkshire Healthcare	30	4.4	2.6	8.7
19. West Middlesex Univ.	60	10.8	6.5	10.8
20. South Tees Acute	122	27.5	16.5	13.5
21. St George's	46	7.8	4.7	10.2
22. Gloucestershire*	32	3.3	2	6.3
23. Dudley Group	137	18.2	10.9	8
24. UCLH	422	40	24	5.6
25. NW London – Cent. Midd.*	69	3.5	2.1	3.4
26. Q. Mary's hospital Sidcup	15	2	1.2	8
27. Nottingham Univ. (QMC)*	17	3	1.8	10.6
28. Sussex Partnership	22	3.9	2.3	10.5
29. North Staffordshire*	28	3.8	2.3	8.2
30. Oxleas	11	1.5	0.9	8.2
31. North East London MH*	11	1.3	0.8	7.3
32. Birm. & Solihull MH	18	6.2	3.7	20.6
33. Cornwall (Bodmin)	10	2.7	1.6	16
34. E. Lond. & City MH (Newh)*	15	1.6	1	6.7
35. Luton & Dunstable	15	1.3	0.8	5.3
36. Northumbria (Wansbeck) *	18	1.4	0.8	4.4

<sup>27</sup> Department of Health, 'Progress of new hospital schemes approved to go ahead'. Available at: [www.dh.gov.uk](http://www.dh.gov.uk) (accessed April 2007).

<sup>28</sup> Department of Health, response to Freedom of Information request, received 30<sup>th</sup> November 2006.

<sup>29</sup> As capital values are those in original business cases, whereas availability charges are current costs as of 2005/06, some of the variation recorded will be due to inflation.

37. Royst. Bunt. & Bishop Stort.	15	2	1.2	8
38. Royal Wolverhampton	13	3.2	1.9	14.6
39. Northumbria (Hexham)*	55	3.9	2.3	4.2
40. Guild. & Waver. (Farnham)*	29	3.2	1.9	6.6
41. Durh. & Darl. (Chester-le-st.)	10	2.1	1.3	13
42. Newbury & Community*	19	3.3	2	10.5
43. Mid Devon PCT (Tiverton)*	10	1.5	0.9	9
44. Leeds (Wharfedale)*	14	1.7	1	7.14
45. Tees Esk & Wear (W. Park)	16	0.8	0.5	3.1
46. Brent - Willesden*	21	3.2	1.9	9
47. Doncaster & S. Humber*	12	1.6	2	16.7
48. Kirklees PCT*	25	1.1	0.7	2.8
49. Sandwell & W Birm.(City)*	26	3.2	1.9	7.3
50. Wandsworth PCT (QMR)	75	2.5	1.5	2
51. Northumberland (Morpeth)*	31	0.4	0.2	0.6
52. Salisbury Health Care*	24	0.4	0.2	0.8
53. East Lancs (Burnley)*	30	2.6	1.6	5.3
<b>Total for operational schemes</b>	<b>2792</b>	<b>468.8</b>	<b>281.3</b>	
<b>Average ratio of capital-to-availability charge</b>				<b>10.1</b>

\* These projects do not include soft facilities management services.

**Table 3 Projected unitary and availability payments for the year 2013/14, for projects that were paying charges in 2005/06**

PFI scheme in operation	Capital value (£m) <sup>30</sup>	Unitary charge in 2013-14 (£m) <sup>31</sup>	Availability charge in 2013-14 (est.) (£m)	Availability charge as % of cap. value
1. North Cumbria Acute	67	18	10.8	16.1
2. Dartford & Gravesham	94	24.4	14.64	15.6
3. Buckinghamshire	45	13.8	8.28	18.4
4. Queen Elizabeth	96	24.5	14.7	15.3
5. Tees Esk & Wear (Durham)	61	16.1	9.66	15.8
6. Tees Esk & Wear (B. Auck.)	48	11	6.6	13.8
7. Calderdale & Huddersfield	65	22.4	13.44	20.7
8. South Manchester Univ.	67	26.4	15.84	23.6
9. Norfolk & Norwich	158	50.8	30.48	19.3
10. Hereford Hospitals	64	14.2	8.52	13.3
11. Barnet & Chase Farm	54	18.4	11.04	20.4
12. Worcestershire Acute	87	27.9	16.74	19.2
13. King's Healthcare	76	21.9	13.14	17.3
14. Swindon & Marlborough	100	23.2	13.92	13.9
15. Leeds Comm & Mental HS	47	10.8	6.48	13.8
16. Bromley Hospitals	118	23.9	14.34	12.2
17. Hull & East Yorkshire*	22	2.6	1.56	7.1
18. Berkshire Healthcare	30	5.4	3.24	10.8
19. West Middlesex Univ.	60	13.1	7.86	13.1
20. South Tees Acute	122	33.5	20.1	16.5
21. St George's	46	9.3	5.58	12.1
22. Gloucestershire*	32	4	2.4	7.5
23. Dudley Group	137	21.6	12.96	9.5
24. UCLH	422	48.7	29.22	6.9
25. NW London – Cent. Midd.*	69	13.1	7.86	11.4
26. Q. Mary's hospital Sidcup	15	2.5	1.5	10
27. Nottingham Univ. (QMC)*	17	3.6	2.16	12.7
28. Sussex Partnership	22	4.7	2.82	12.8
29. North Staffordshire*	28	4.7	2.82	10.1
30. Oxleas	11	1.8	1.08	9.8
31. North East London MH*	11	1.5	0.9	8.2
32. Birm. & Solihull MH	18	7.6	4.56	25.3
33. Cornwall (Bodmin)	10	3.2	1.92	19.2
34. E. Lond. & City MH (Newh)*	15	1.5	0.9	6
35. Luton & Dunstable	15	1.5	0.9	6
36. Northumbria (Wansbeck) *	18	2.2	1.32	7.3
37. Royst. Bunt. & Bishop Stort.	15	2.4	1.44	9.6
38. Royal Wolverhampton	13	3.9	2.34	18
39. Northumbria (Hexham)*	55	7.7	4.62	8.4

<sup>30</sup> Department of Health, 'Progress of new hospital schemes approved to go ahead'. Available at: [www.dh.gov.uk](http://www.dh.gov.uk) (accessed April 2007).

<sup>31</sup> Department of Health, response to Freedom of Information request, received 30<sup>th</sup> November 2006. Unitary charges and figures derived from them are in nominal terms.

40. Guild. & Waver. (Farnham)*	29	3.8	2.28	7.9
41. Durh. & Darl. (Chester-le-st.)	10	2.6	1.56	15.6
42. Newbury & Community*	19	4	2.4	12.6
43. Mid Devon PCT (Tiverton)*	10	1.8	1.08	10.8
44. Leeds (Wharfedale)*	14	2.1	1.26	9
45. Tees Esk & Wear (W. Park)	16	0.9	0.54	3.4
46. Brent - Willesden*	21	3.5	2.1	10
47. Doncaster & S. Humber*	12	2.1	1.26	10.5
48. Kirklees PCT*	25	2.5	1.5	6
49. Sandwell & W Birm.(City)*	26	3.8	2.28	8.8
50. Wandsworth PCT (QMR)	75	12.1	7.26	9.7
51. Northumberland (Morpeth)*	31	5.9	3.54	11.4
52. Salisbury Health Care*	24	2.9	1.74	7.3
53. East Lancs (Burnley)*	30	3.7	2.22	7.4
<b>Total for operational schemes</b>	<b>2792</b>	<b>599.5</b>	<b>359.7</b>	
<b>Average ratio of capital-to-availability charge</b>				<b>12.9</b>

\* These projects do not include soft facilities management services.

**Table 4. Unitary and availability payments in 2013/14 for schemes recently completed or under construction**

Recently completed scheme or scheme under construction	Capital value (£m) <sup>32</sup>	Projected unitary charge in 2013-14 (£m) <sup>33</sup>	Availability charges in 2013-14 (est.) (£m)	Availability charge as % of cap. value
1. Avon & West Wilts*	83	7.4	4.4	5.3
2. East Lancs (Blackburn)*	110	13.1	7.9	7.2
3. Bucks - Stoke Mandeville	47	11.9	7.1	15.1
4. Newham Healthcare	52	13.3	8	15.3
5. Walsgrave	379	64.1	38.5	10.1
6. Derby Hospitals	312	42.9	25.7	8.2
7. Oxford Radcliffe 1	134	22.0	13.2	9.8
8. Barking, Hav. and Redbridge	238	36.6	22	9.2
9. Brighton Health Care*	36	4.8	2.9	8.1
10. Lewisham Hospital*	72	6.7	4	5.6
11. Leeds Teaching*	265	22.1	13.3	5
12. Central Manch/ Childrens	512	54.4	32.6	6.4
13. Newcastle*	299	28.6	17.2	5.7
14. Sherwood Forest	326	36.7	22	6.7
15. Portsmouth	236	36.3	21.8	9.2
16. Oxford Radcliffe 2	129	17.8	10.7	8.3
17. Hull & East Yorks*	67	4.6	2.8	4.2
18. Barts & The London	1000	96.4	57.8	5.8
19. St Helens & Knows	338	34.5	20.7	6.1
20. Univ. Birm./ Birm & Sol. MH	627	46	27.6	4.4
21. The Whittington*	32	4.4	2.6	8.1
22. Kingston Hospital	28	9.2	5.5	19.6
23. Nuffield Orthopaedic Centre	37	5.2	3.1	8.4
24. Sheffield Teaching Hospitals*	30	3	1.8	6
25. Hampshire PCT - Lymington	36	5.3	3.2	8.9
26. Camb. Uni. (Addenbrkes)*	76	7.4	4.4	5.8
27. Northgate & Prud. (Neuro)*	24	1.7	1	4.2
28. Nottinghamshire*	19	2.6	1.6	8.4
29. Ipswich Hospital*	36	3.4	2	5.6
30. Northampts Teach. PCT*	28	2.4	1.4	5
31. SW. Essex Teach. PCT	30	3.7	2.2	7.3
32. Taunton & Somerset	21	2.3	1.4	6.7
<b>Total in construction/recently in operation</b>	<b>5659</b>	<b>650.5</b>	<b>390</b>	
<b>Average ratio of capital-to-availability charge</b>				<b>6.9</b>

\* These projects do not include soft facilities management services.

<sup>32</sup> Department of Health, 'Progress of new hospital schemes approved to go ahead'. Available at: [www.dh.gov.uk](http://www.dh.gov.uk) (accessed April 2007).

<sup>33</sup> Department of Health, response to Freedom of Information request, received 30<sup>th</sup> November 2006. Unitary charges and figures derived from them are in nominal terms.

**Table 5. Charges in 2013/14 for PFI hospital schemes in procurement or in planning**

<b>In procurement</b>	<b>Capital Value (£m)<sup>34</sup></b>	<b>Est. Unitary charges by 2013-14 (£m)<sup>35</sup></b>	<b>Availability charges in 2013-14 (est.) (£m)</b>
1. Univ. Hospital of North Staffs	272	40.3	24.2
2. Univ. Hospitals of Leicester	711	105.2	63.1
3. Mid Yorks - Wakefield	343	50.8	30.5
4. North Middlesex Hospitals	111	16.4	9.8
5. Mid Essex Hospitals	143	21.2	12.7
6. Salford Royal Hospitals	190	28.1	16.9
7. Tameside & Glossop	109	16.1	9.7
8. Peterborough & Stamford FT	280	41.4	24.8
9. Walsall Hospitals	141	20.9	12.5
10. Maidstone/Tunbridge Wells	225	33.3	20
11. Tees, Esk & Wear Valleys	78	11.5	6.9
12. Leicestershire Partnership	50	7.4	4.4
13. Derbyshire Mental Health	29	4.3	2.6
14. South Essex Partnership	30	4.4	2.6
15. Redcar & Cleveland PCT	40	5.9	3.5
16. Lincolnshire Teach. (MH)	26	3.8	2.3
17. Northamps Healthcare	36	5.3	3.2
18. Blackpool PCT	20	3	1.8
19. Leic. & Rutland (MR&H)	32	4.7	2.8
20. Leic. & Rutland (H&B)	36	5.3	3.2
21. Tees Esk & Wear Cty Durh.	40	5.9	3.5
<b>Sub Total</b>	<b>2942</b>	<b>435.2</b>	<b>261</b>
<b>In planning</b>			
22. Royal Nat. Orthopaedic	144	21.3	12.8
23. Hillingdon Hospital	139	20.6	12.4
24. United Bristol Healthcare	80	11.8	7.1
25. Royal Wolverhampton	200	29.6	17.8
26. Southampton University	60	8.9	5.3
27. East and North Hertfordshire	250	37	22.2
28. West Hertfordshire Hospitals	200	29.6	17.8
29. North Bristol/South Glouc.	310	45.9	27.5
30. Papworth Hospital	148	21.9	13.1
31. Sandwell and West Birm.	500	74	44.4
32. Taunton and Somerset	79	11.7	7
33. Southend Hospital	100	14.8	8.9
34. Northum., Tyne & Wear	50	7.4	4.4
35. NW London Hospitals	305	45.1	27

<sup>34</sup> Department of Health, 'Progress of new hospital schemes approved to go ahead'. Available at: [www.dh.gov.uk](http://www.dh.gov.uk) (accessed April 2007).

<sup>35</sup> These estimates are based on the average unitary charge-to-capital value ratio for schemes in Tables 3 and 4 (that is, 14.8%). The estimate is necessarily a rough one, since unitary payments vary over time and the scope of each project (in terms of which services are included) has not yet been decided. Unitary charges and figures derived from them are in nominal terms.

36. Heatherwood/Wexham Park	200	29.6	17.8
37. Barnet & Chase Farm	40	5.92	3.6
38. R. Liverpool & Broadgreen	225	33.3	20
39. Mersey Care	170	25.2	15.2
40. Royal Liverpool Children's	300	44.4	26.7
41. Leeds Teaching Hospitals	600	88.8	53.3
<b>Sub Total</b>	<b>4100</b>	<b>606.8</b>	<b>364.3</b>
<b>TOTAL</b>	<b>7042</b>	<b>1042</b>	<b>625.3</b>
<b>Average ratio of capital-to-availability charge</b>			

**Table 6 Increases to the capital cost of ‘prioritised’<sup>36</sup> PFI schemes between Outline Business Case and contracts being signed**

	Capital Value at OBC (£m) <sup>37</sup>	Capital Value at Close (£m) <sup>38</sup>	Change (%)
<b>PFI scheme in operation</b>			
1. North Cumbria Acute	39	67	41.8
2. Dartford & Gravesham	96	94	-2.1
3. Buckinghamshire	23.7	45	89.9
4. Queen Elizabeth	57.1	96	68.1
5. Tees Esk & Wear (Durham)	55.2	61	10.5
6. Calderdale & Huddersfield	31	65	109.7
7. South Manchester University	65.6	67	2.1
8. Norfolk & Norwich	122.9	158	28.5
9. Hereford Hospitals	44.1	64	45.1
10. Barnet & Chase Farm	54	54	0
11. Worcestershire Acute	64.3	87	35.3
12. Tees Esk & Wear (Bishop Auckland)	20	48	140
13. King's Healthcare	77.2	76	-1.6
14. Swindon & Marlborough FT	45	100	55
15. Leeds Comm. & Mental HS	39	47	20.5
16. Bromley Hospitals	112.1	118	5.3
17. Hull & East Yorkshire	21.7	22	1.4
18. Berkshire Healthcare	29.4	30	2.1
19. West Middlesex Univ.	38.2	60	57
20. South Tees Acute	51.2	122	123.8
21. St George's	31.4	46	46.5
22. Gloucestershire	32	32	0
23. Dudley Group	67.7	137	102.4
24. UCLH	115	422	267
25. NW London – Central Middlesex	55	69	25.5
26. Avon & Western Wiltshire	68	83	22
27. East Lancashire (Blackburn)	70.3	110	56.5
28. Walsgrave	178	379	112.9
29. Oxford Radcliffe 1	60	134	123.3
30. Barking, Havering & Redbridge	145.6	238	63.5
31. Lewisham Hospital	44	72	63.6
<b>SCHEMES UNDER CONSTRUCTION</b>			
32. Derby Hospitals NHS FT	177	312	76.2
33. Brighton Health Care	30.9	36	16.5
34. Leeds Teaching Hospitals	125	265	112

<sup>36</sup> These projects tend to be large ‘whole hospital’ procurements, as opposed to smaller scale investments. They were ‘prioritised’ by the Labour government due to their size and importance.

<sup>37</sup> Capital values are in original prices. Drawn from Health Expenditure Memoranda, 1999-2000 to 2003-04.

<sup>38</sup> Department of Health, ‘Progress of new hospital schemes approved to go ahead’. Available at: [www.dh.gov.uk](http://www.dh.gov.uk) (accessed April 2007).

35. Central Manchester /Manchester Childrens	127	512	303
36. Newcastle Upon Tyne Hospitals	129.5	299	130.9
37. Sherwood Forest Hospitals	66	326	393.9
38. Portsmouth Hospitals	127.7	236	84.8
39. Oxford Radcliffe Hospitals 2	95	129	35.8
40. Hull & East Yorkshire	37.6	67	78.2
41. Barts & The London	620	1,000	61.3
42. St Helens & Knowsley Hospitals	211	338	60.9
43. University Hospital Birmingham/ Birmingham & Solihull Mental Health	291	627	115.5
<b>AVERAGE INCREASE</b>			<b>74</b>

**Table 7 Capital and availability charges for all NHS trusts\* with operational PFI hospitals in 2005/06**

	a <sup>39</sup>	b <sup>40</sup>	C <sup>41</sup>	d (a+b+c)	E <sup>41</sup>	F (a+b+c/e)
<b>NHS trust</b>	<b>Availability charge in 2005/06 (£m)</b>	<b>Depreciation/ Amortisation in 2005/06 (£m)</b>	<b>Dividend paid on PDC (£m)</b>	<b>All charges in 2005/06 (£m)</b>	<b>Total trust income 2005/06 (£m)</b>	<b>All charges as percentage of total income (%)</b>
1. North Cumbria Acute Hospitals	8.9	4.7	2.4	16	172.6	9.3
2. Dartford & Gravesham	12	1.5	0.8	14.3	101.9	14.0
3. Buckinghamshire Hospitals	6.8	9.0	5.7	21.5	228.1	9.4
4. Queen Elizabeth Hospital	12.4	1.2	1.9	15.5	133.0	11.7
5. County Durham and Darlington Priority (now Tees, Esk and Wear)	15.1 (for all four schemes)	7.6	5.4	28.1	79.5	35.3
6. Calderdale & Huddersfield	11	5.1	5.7	21.8	248.9	8.8
7. South Manchester University Hospital	13	6.2	4.6	23.8	252.4	9.4
8. Norfolk & Norwich University Hospital	25	5.1	1.5	31.6	300.0	10.5
9. Hereford Hospitals	7	1.9	0.6	9.5	84.8	11.2
10. Barnet & Chase Farm Hospitals	9	8.1	8.7	25.8	252.1	10.2
11. Worcestershire Acute Hospitals	13.7	8.3	4.8	26.8	246.1	10.9
12. King's College Hospital (now King's Healthcare)	11	9.9	7.3	28.2	388.0	7.3
13. Swindon & Marlborough	11.4	2.3	1.9	15.6	157.6	9.9
14. Leeds Mental Health Teaching	5.3	1.3	0.8	7.4	100.3	7.4
15. Bromley Hospitals	11.8	6.0	4.8	22.6	153.5	14.7
16. Hull & East Yorkshire	1.3	5.4	6.7	13.4	334.3	4.0
17. Berkshire Health	2.6	1.4	1.0	5	104.6	4.8
18. West Middlesex University	6.5	3.0	2.4	11.9	103.1	11.5
19. South Tees Acute	16.5	7.0	5.7	29.2	318.1	9.2

<sup>39</sup> Unitary charges figures were derived from Department of Health, response to Freedom of Information request, received 30<sup>th</sup> November 2006. These were then reduced by 40%, reflecting the service charge component.

<sup>40</sup> Department of Health, response to Freedom of Information request, received 9<sup>th</sup> July 2007.

Hospitals						
20. St George's Healthcare	4.7	13.0	6.6	24.3	336.9	7.2
21. Gloucestershire Partnership	2	1.7	2.1	5.8	83.5	6.9
22. Dudley Group of Hospitals	10.9	3.1	3.0	17	185.0	9.2
23. North West London Hospitals*	2.1	13.5	6.2	21.8	271.9	8.0
24. Queen Mary's Hospital Sidcup	1.2	4.8	2.6	8.6	89.4	9.6
25. Nottingham University Hospitals	1.8	10.2	6.7	18.7	302.1	6.2
26. University Hospital of North Staffordshire	2.3	14.1	6.6	23	299.6	7.7
27. Oxleas	0.9	2.5	4.7	8.1	126.0	6.4
28. North East London MH	0.8	3.1	4.1	8	105.2	7.6
29. Birm. & Solihull MH	3.7	3.3	4.2	11.2	175.1	6.4
30. Cornwall Partnership (now Cornwall Healthcare)	1.6	0.8	0.7	3.1	85.2	3.6
31. East London & City MH	1	4.3	2.5	7.8	156.9	5.0
32. Luton & Dunstable Hospital	0.8	4.5	2.5	7.8	143.6	5.4
33. Northumbria Healthcare (inc. 2 schemes)	3.1	5.6	6.1	14.8	236.8	6.3
34. Royal Wolverhampton	1.9	10.3	8.0	20.2	222.6	9.1
35. Leeds Teaching Hospitals	1	22.4	13.8	37.2	721.4	5.2
36. Doncaster & S. Humber	2	2.2	2.4	6.6	89.6	7.4
37. Sandwell & W Birm.(City)	1.9	13.1	8.3	23.3	313.4	7.4
38. Newcastle, North Tyneside and Northumberland MH	0.2	2.6	3.3	6.1	123.3	4.9
39. Salisbury Health Care	0.2	7.2	3.4	10.8	140.2	7.7
40. East Lancashire	1.6	19.4	7.2	28.2	274.0	10.3
<b>Total/Average</b>	<b>244.9</b>	<b>256.7</b>	<b>177.7</b>	<b>680.0</b>	<b>8,240.2</b>	<b>8.3</b>

\* Foundation trusts and Primary care trusts (PCTs) are not included here

**Table 8 Capital and availability charges for NHS trusts\* with operational PFI schemes with a capital value of more than £50 million, in 2005/06**

NHS trust	a <sup>41</sup> Availability charge in 2005/06 (£m)	b <sup>42</sup> Capital value	C <sup>43</sup> Depreciation/ Amortisation in 2005/06 (£m)	d (a+b+c) Dividend paid on PDC (£m)	e <sup>43</sup> All charges in 2005/06 (£m)	F (a+b+c/e) Total trust income 2005/06 (£m)	a <sup>43</sup> All charges as percentage of total income (%)
1. North Cumbria Acute Hospitals	8.9	67	4.7	2.4	16	172.6	9.3
2. Dartford & Gravesham	12	94	1.5	0.8	14.3	101.9	14.0
3. Queen Elizabeth Hospital	12.4	96	1.2	1.9	15.5	133.0	11.7
4. County Durham and Darlington Priority (now Tees, Esk and Wear)	15.1 (for all four schemes)	109 (61+48)	7.6	5.4	28.1	79.5	35.3
5. Calderdale & Huddersfield	11	65	5.1	5.7	21.8	248.9	8.8
6. South Manchester University Hospital	13	67	6.2	4.6	23.8	252.4	9.4
7. Norfolk & Norwich University Hospital	25	158	5.1	1.5	31.6	300.0	10.5
8. Hereford Hospitals	7	64	1.9	0.6	9.5	84.8	11.2
9. Barnet & Chase Farm Hospitals	9	54	8.1	8.7	25.8	252.1	10.2
10. Worcestershire Acute Hospitals	13.7	87	8.3	4.8	26.8	246.1	10.9
11. King's College Hospital (now King's Healthcare)	11	76	9.9	7.3	28.2	388.0	7.3
12. Swindon & Marlborough	11.4	100	2.3	1.9	15.6	157.6	9.9
13. Bromley Hospitals	11.8	118	6.0	4.8	22.6	153.5	14.7
14. West Middlesex University	6.5	60	3.0	2.4	11.9	103.1	11.5
15. South Tees Acute Hospitals	16.5	122	7.0	5.7	29.2	318.1	9.2
16. Dudley Group of Hospitals	10.9	137	3.1	3.0	17	185.0	9.2
17. North West London Hospitals*	2.1	69	13.5	6.2	21.8	271.9	8.0
18. Northumbria	3.1	69	5.6	6.1	14.8	236.8	6.3

<sup>41</sup> Unitary charges figures were derived from Department of Health, response to Freedom of Information request, received 30<sup>th</sup> November 2006. These were then reduced by 40%, reflecting the service charge component.

<sup>42</sup> Department of Health, response to Freedom of Information request, received 9<sup>th</sup> July 2007.

<sup>43</sup> Unitary charges figures were derived from Department of Health, response to Freedom of Information request, received 30<sup>th</sup> November 2006. These were then reduced by 40%, reflecting the service charge component.

Healthcare (inc. 2 schemes)		(55+14)					
<b>Total for operational schemes</b>	<b>200.4</b>		<b>100.1</b>	<b>73.8</b>	<b>374.3</b>	<b>3,685.3</b>	<b>10.2</b>

\* Foundation trusts and Primary care trusts (PCTs) are not included here