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February 2009

by Chris Edwards

Number 45

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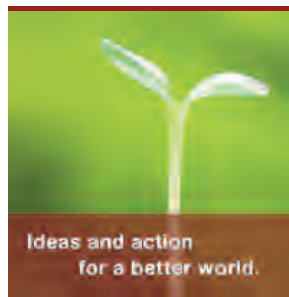
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Compass publications are intended to create real debate and discussion around the key issues facing the democratic left - however the views expressed in this publication are not a statement of Compass policy.



The Private Finance Initiative and the National Health Service – time to buy out the contracts?

by Chris Edwards¹

Investment in the National Health Service (NHS) – the good news and the bad news

It is noteworthy that after more than sixty years of the NHS, it can be claimed that the services are still more or less free at the point of use. As a Civitas report has pointed out, sick patients in the UK very rarely fail to use medical services on the grounds of costs (as compared to the USA and Germany) (see Gubb 2006, 40).

Furthermore credit must go to the Labour Government for increasing expenditure on the NHS so rapidly since 1997. Whereas between 1981 and 1998, real NHS expenditure rose at an annual average rate of less than 3 per cent, from 1999 it began to accelerate rapidly and in the five years between 2002/03 and 2007/08, real spending on the NHS rose by an average of 7.4 per cent a year (Wanless et al 2007, xviii). As a result, whereas public expenditure on health, as a percentage of the UK's Gross Domestic Product, was less than 5.4 in 1997/98 and was down to 5.3 in 1999/2000, by 2007/08 it had risen to 7.3².

Furthermore real expenditure on the NHS in the near future looks set to continue to rise. In 2007/08 the estimated gross expenditure (current and capital) on the NHS was £96 billion and under the Government's Comprehensive Spending Review of 2007, which set out the spending plans from 2008/09 to 2010/11, NHS expenditure was budgeted to grow in real terms by 4 per cent a year (see Department of Health, May 2008, 1, 146).

That's the good news.

The bad news is that the NHS is being privatised with much of the investment in the NHS being financed by the private sector. This would have horrified Aneurin Bevan, under whose leadership (as the Minister of Health and Housing in the Attlee Government), the National Health Service was established. Bevan had argued for four principles for the health service – free at the point of use, universal in reach, publicly funded and responsible usage by the public (see Hayhurst, May 2005). It was in 1951 when the first of these principles was broken (with the imposition of prescription charges) that Bevan resigned from the Gaitskell government.

Clearly the use of the Private Finance Initiative (PFI) violates the third of Bevan's four principles as would other initiatives which have advanced privatisation in the National Health Service. The PFI is the scheme whereby companies in the private sector not only build new hospitals but also finance them and rent them back to the NHS over long contract periods of more than 30 years.

Of course, the PFI covers more sectors than just health but this article is based on research that I have carried out on PFI in the hospital sector. However it is worth emphasising that within the NHS, the PFI model is also being applied to primary care premises (General Practice surgeries and health centres) in the form of the NHS Local Improvement Finance Trust or LIFT. By March 2007, about 30 companies held commercial contracts to provide primary care services in England through their ownership of 74 health centres and general practices (Pollock et al, September 2007, 475). The 2008 Annual Report of the Department of Health stated that "NHS LIFT has now attracted over £1.3 billion of private capital investment and this level of investment will continue to grow in 2008/09 and beyond" (Department of Health May 2008, 179).

Since 2004/05, the role of PFI investment in the NHS has grown rapidly, and over

the past two years (2006/07 and 2007/08), it accounted for about a fifth of total capital investment (Department of Health, May 2008, 174). Furthermore, when we look within the NHS at the hospital sector, the role of PFI has been even more important. The NHS Plan of 2000 set a target of over 100 new hospital schemes by the end of 2010. By the end of 2007, 93 new hospital schemes were operational, of which 70 were PFI schemes. In its 2008 report, the Department of Health reported that a further 14 PFI hospital schemes were underway and more were envisaged (Department of Health, May 2008, 179).

The inevitably higher cost of PFI projects

It is clear that a major effect of PFI has been to make the hospital investment programme much more expensive than it would have been with public finance. The reason for this is simple. The annual cost of capital for private financing (at 10 per cent) is more than double that of public sector financing (at 4.3 per cent).

How are these cost of capital figures derived? The annual cost of capital on PFI projects in general is about 10 per cent as shown in research by Edwards³ et al 2004.

Furthermore, payments on all PFI projects over the next 30 years will total £180.7 billion – or an average of a little over £6 billion a year (PAC 2008, page Ev 11). On a capital value of these projects of £56.9 billion, this implies an annual capital recovery factor of 1.06⁴ which in turn is equivalent to an annual interest rate of almost exactly 10 per cent.

This article is based on research which has focussed on hospitals and in particular on the Norfolk and Norwich University Hospital (NNUH) (see the box below). The private cost of capital at the NNUH has also averaged 10 per cent a year:



The Norfolk and Norwich University Hospital (NNUH); a brief background

The NNUH replaced two previous city-centre based hospitals; the former West Norwich Hospital and the old Norfolk and Norwich Hospital. The West Norwich is now the Norwich Community Hospital and is run by the NHS Norfolk primary care trust while the site of the Norfolk and Norwich Hospital was sold, with the hospital being demolished and replaced by housing.

After much discussion since the 1960s over the location of a new hospital, in March 1996, the East Norfolk Health Commission approved the full business case for a 701-bed new hospital at Colney, a few miles west of Norwich City Centre and close to the University of East Anglia (UEA). These 701 beds compared with over 1200 beds at the two old hospitals, a reduction of over 40 per cent. The sharp drop was not justified by changes in clinical practices, such as shorter lengths of stay for in-patients and a rise in day-case treatments. Instead, in the 1990s, the number of beds for the new hospital was manipulated to make the new hospital more 'affordable' as a PFI project. Once approved, the size of hospital was increased so that the present hospital has 987 beds, still over 200 beds less than the capacity of the old hospitals.

The NNUH was one of the first and largest of the PFI hospitals to be built. In November 1996, a PFI contract was signed between Octagon Healthcare (the PFI consortium) and the Norfolk and Norwich Health Care NHS Trust. In January 1998, construction work started on the new hospital at Colney and it was completed in 2001. In the meantime the Health Secretary had announced that UEA would have a medical school and that the new hospital would be a University teaching hospital. In 2001, the Trust was established as the NNUH NHS Trust.

The cost of the hospital is given in the NNUH Trust accounts as £229 million but

the building construction cost is given in a National Audit Office report of 2005 as £159 million (NAO June 2005, 18). On top of the £159 million, development costs for the approach roads, for IT hardware and for catering and other equipment accounted for at least £17 million but financial fees, tender cost and interest charged during construction by Octagon Healthcare totalled at least a further £46 million (see UK Parliament July 1999). These costs are in addition to 'PFI set-up costs' of about £13 million paid for by the Trust itself between 1995 and 2001.

By contrast to the private annual cost of capital of 10 per cent, the Government's cost of borrowing as measured by the yield in real terms on government bonds for the 20 years between 1981 and 2000 averages 4.3 per cent per annum.

If we plug these costs of capital (10 and 4.3 per cent) into a financial model for a hospital⁵, we find that over of a 25 year period and using the Treasury's rate of discount of 3.5 per cent per annum, the privately-financed construction cost would have to be 38 per cent lower than the publicly-financed version to compensate for the higher financial cost and to give equivalent value for money. Over an even longer period – for example the 39-year PFI contract period of the NNUH – the construction cost of the privately-financed version would have to be 48 per cent lower than the publicly-financed version to give the same value for money.

Given the much higher financing costs of private capital, it is hardly surprising to find that PFI schemes are generally poor value for money. This is not just true of hospitals but of other PFI projects as well.

Value for money? No, for the public sector; yes, for the private sector

It is almost inevitable that PFI schemes provide poor value for money, since financing hospitals through the PFI is a bit like financing the purchase of a house

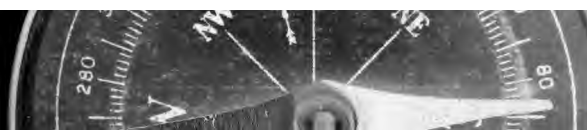
through a credit card rather than a mortgage.

How is it then that in business case after business case⁶ in which the PFI cost has been compared with a Public Sector Comparator, the PFI alternative has been shown to be narrowly cheaper? The reason is again simple. In general, the figures were fiddled. Why? Because the comparisons were never serious. It was invariably made clear to the managers in the health sector that there was no alternative to a PFI version. The message was; "you can have a new hospital so long as it is a privately-financed one". This was true of the NNUH as well as many other hospitals.

The private/public comparisons were manipulated in two ways.

The first way was by assuming that the costs of a publicly-financed version would overrun by an unrealistically high percentage. Publicly-funded projects were often said to suffer from optimism bias with the estimates being shown to be too 'optimistically' low because of overruns in cost and/or time. The Business Case for the NNUH in 1996 was a good example. The overrun was assumed to be 34 per cent even though around that time the maximum overrun on standard projects (such as hospitals) was 24 per cent and the average overrun was 13 per cent. This was the judgement of a report for the government by Mott MacDonald, the consulting engineers (Mott MacDonald, 2002). It is worth emphasising that the Mott MacDonald report has itself been criticised for exaggerating the overruns (see Pollock et al 2007).

The second way in which the figures were fiddled was by making comparisons at different stages in the project cycle. As Hellowell and Pollock have shown for 43 large PFI hospital schemes, the capital costs at the final contract stage were an average of 74 per cent above the estimated costs at the outline business case stage. The escalation for the NNUH was 28.5 per cent (see Hellowell and



Pollock, 2007, table 6). Therefore it is important that the comparisons are made at the same stage for both the private and public sector. This does not seem to have always been the case.

However these comparisons are difficult to check because of the secrecy and obscurity of many of the Business Cases (see also for similar complaints, Edwards et al 2004, 12 and 23; Sussex 2001, 42; and UK Parliament 2002 paragraph 70). The NNUH is no exception with the Chair of the Select Committee on Health becoming frustrated with its 1996 Business Case and saying; "In other words, the full business case does not tell us the full business case" (UK Parliament May 1999, paragraph 20).

In short, the value for money comparisons in the Business Cases are not to be trusted. With reference to this, Tim Gosling has stated that; "...a senior figure at the NAO publicly described some comparators as 'pseudo-scientific mumbo-jumbo where financial modelling has taken over from thinking'" (Gosling (ed) 2004, 29).

Because the private cost of capital is more than twice that of the public sector, it is almost inevitable that PFI hospitals will provide very poor value for public money. By contrast, such projects provide very good value for private money. They offer a relatively risk-free way through which the shareholders of the companies raising the finance for the projects can make very high returns indeed.

This is illustrated at the NNUH. As stated in the Box above, the company involved in the PFI project at the NNUH is Octagon Healthcare. The published accounts of Octagon Healthcare show that the shareholders' funds at the end of 1998 totalled £1.325 million. Five years later, in the year ending 31 December 2003, the dividends paid to these shareholders totalled £11 million. At 2003 prices, the share capital was equivalent to £1.47 million in which case the dividend payments were more than seven times as great as the share capital - and there were

still more than 30 years of profits to come.

The dividends were paid from the massive windfall profit that Octagon Healthcare made on the refinancing of the NNUH project in December 2003. The project was refinanced by Octagon Healthcare with lower-interest bond financing being substituted for higher-interest bank financing. The immediate cash gain to Octagon's investors was £95 million while the NNUH gained £34 million in the form of reduced rent over the life of the project.

The refinancing was a poor deal for the NNUH, since if the NNUH Trust wants to buy out the contract, the NNUH has to pay off Octagon's liabilities and with the refinancing, these had been raised sharply. In its report, the Committee of Public Accounts pointed out that; "The Trust might now have to pay up to 257 million pounds more if it needs to terminate the contract early. This is taxpayers' money and the risk of this large liability was incurred essentially so that investors could have fatter returns" (PAC 2006, press notice).

Octagon's windfall profit of £95 million on the refinancing deal in 2003 represented an annual rate of return on £1.47 million of share capital (in 2003 prices) of more than 120 per cent even without taking account of net profits after tax of £3.6 million in 2001 and £1.6 million in 2002.

The deal was such a poor one for the NNUH that Edward Leigh, the Conservative chair of the Public Accounts Committee, stated that; "we would not expect to see another Accounting Officer appearing before this Committee defending what we believe to be the unacceptable face of capitalism in the consortium's dealings with the public sector" (PAC 2006, 3).

To emphasise how profitable PFI projects are for the private sector, it is useful to look at the accounts of Innisfree Limited which, at the end of 2007 owned 26.3 per cent of the shares of Octagon Healthcare⁷.

On March 31, 2008, this company had seven directors, one of whom was David Metter who has become the driving force behind the Public Private Partnership (PPP) Forum (Guardian, February 22, 2003).

As of 31 March 1998, the shareholders' funds of Innisfree Limited totalled about £260,000. If we take the annual cash flow to shareholders as consisting of the remuneration to the seven directors plus the dividends paid, the average annual return on shareholders' funds over the ten years from 1999 to 2008 (inclusive) was 162 per cent.

It is hardly surprising that the Investors Chronicle has called PFI shareholdings 'hidden gems' waiting to be discovered by the financial markets (see BBC, Tuesday July 6 2004, page 13 transcript). Peter Mandelson has been quoted as saying that "New Labour is intensely relaxed about people getting filthy rich" (quoted by Geoffrey Wheatcroft in the Guardian of February 14 2005) in which case, New Labour is, doubtless, intensely relaxed about the PFI⁸.

Public sector debt and the Labour Government's attraction to private financing

It seems that the main reason for the Labour Government being attracted to PFI since 1997 is that using the PFI would help it to achieve two fiscal rules seen to be a key requirement for long-term economic stability. One was to keep public sector debt below 40 per cent of GDP and the other was to balance the government's books over the medium term (current expenditure should not exceed current income over the life of the economic cycle).

The 40 per cent debt target is widely thought to be an unnecessarily stringent one. It compares with figures of above 60 per cent (as at the end of 2008) for the USA, France, Germany, Italy and Japan (Guardian, January 22, 2009). And even though the UK target has been smashed by the effects of the credit crunch, the



debt-to-GDP percentage at the end of 2008 was 47.5 per cent (at £698 billion), still considerably less than 60 per cent of GDP.

With such a tight debt target, it is not surprising that PFI projects were attractive to the Labour Government because PFI liabilities have not, in general, appeared as public sector debt. Why is this? The reason is because the Government considers the risks of these projects to be borne by the private sector.

What difference would it make if these projects were on the public sector's balance sheet? According to a recent report of the Public Accounts Committee, the total capital value of PFI projects as at November 2007 was £56.9 billion of which £23.9 billion was on the public sector's balance sheet (PAC 2008, page Ev 11). Thus £33 billion was not on the public sector's balance sheet. This is about 2.3 per cent of the GDP as of the same date.

This is, of course, a small percentage given the likely growth in the debt/GDP percentage from about 30 per cent in 2002/03 to 47.5 per cent at the end of 2008 to a projected 57.5 per cent by 2013/14.

With the hindsight of the credit crunch, it seems absurd for the Government to have so enthusiastically adopted a Private Finance Initiative strategy which provides such poor value for money. PFI is a high price to pay to hide the investment from public sector debt. Over the next 30 years, the government is committed to paying a total of £180.7 billion on PFI projects or an average of a little over 6 billion a year on a capital value of £56.9 billion (PAC 2008, page Ev 11). If the same projects had been financed by the public sector and the construction cost had been the same, the repayments would be averaging £3.4 billion a year, a saving of about £2.6 billion a year. This is equivalent to about £2.1 billion at 1999 prices, when the NNUH hospital was built - at a construction cost of £159 million. Thus the saving would have been enough to build

13 NNUH hospitals each year. To recap. The Government has attempted to keep much of hospital investment off the public sector's balance sheet in a futile attempt to attain one fiscal rule, namely to keep the Public Sector Net Debt below 40 per cent of GDP. But in attempting this, it has expanded investments under the Private Finance Initiative and has paid an interest rate of over twice the public sector's rate. As a result, the higher costs of PFI threaten to either push up future debt or raise taxes.

As stated earlier, alongside the macro-objective of hiding the public debt, the Government has adopted the micro-rhetoric that the PFI schemes must show value for money. The lesson that comes from this analysis is that because of the higher cost of capital of the private sector, the PFI was never likely to provide value for money. And it hasn't.

As a health economist, Jon Sussex has put it; "The often heard argument over whether PFI 'permits' more investment than conventional Exchequer financing is a red herring. The taxpayer will eventually pay, either way" (2001, 7). Similarly the shadow chancellor, George Osborne, has been quoted as saying that Gordon Brown has used PFI to "get money off the balance sheet" but that, in so doing, "very bad deals were struck which I think will cost the taxpayer for many, many years to come" (Guardian, September 8, 2008).

The PFI burden at the NNUH

In conclusion, PFI is, to say the least, highly problematic. As I have said, my research has focussed on PFI in the hospital sector with particular emphasis on the Norfolk and Norwich University Hospital (NNUH).

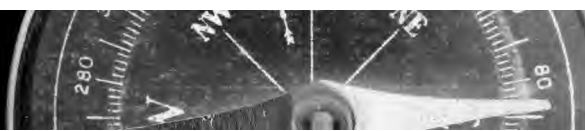
I calculate that the extra cost imposed annually on the NNUH as a result of the PFI contracts is a minimum of £18.8 million (at 2007 prices). This is the extra rent payable as a result of the PFI contract. But this is a minimum. In addition there could be other higher costs as a

result of higher buildings maintenance and service charges (catering, portering, etc.). I would need to have access to more detailed accounts than the published ones to estimate these.

Furthermore, in addition to these, there have been higher costs incurred because of the Primary Care Trust having to purchase beds from private hospitals at higher unit costs than at the NNUH. In 2005, Chris Humphris of the Southern Norfolk Primary Care Trust⁹ stated that; "the Norfolk and Norwich Hospital had purchased beds from the private sector at higher cost because it was unable to carry out all the work itself" (sixth page of the minutes of a meeting between Norfolk MPs and NHS officials held on February 11 2005). In a subsequent letter to Richard Bacon dated 17 March 2005, Chris Humphris stated that in the year 2004/05, the PCTs in Norfolk were expecting to spend £4 million on private sector work and that this was costing £800,000 more than if the NNUH had carried out the work. This purchase of beds from private hospitals (such as Spire and Bupa) is attributable to the PFI contract since, as pointed out in the Box above, the size of the NNUH was deliberately restricted to make the PFI project 'affordable'.

In the years since 2004/05, it is likely that the purchase of treatment at private hospitals in the region has risen even further given the pressure on beds which the NNUH has experienced. On January 16 2009, I wrote to the Chief Executives of the Norfolk Primary Care Trust and of the NNUH asking the following question; how many patients have been treated at private hospitals in the last two years (2006/07 and 2007/08) as a result of the NNUH not having the capacity to treat them and at what cost?

At the time (February 1, 2009) of completing this article, a reply is awaited.



What is to be done? Should the PFI contract at the NNUH be bought out?

What, if anything, can be done? After all, the NNUH is in its eighth year of payments for the PFI contract and, up to the end of the 2007/08 financial year, had already paid a total of £197 million in rent (in 2007 prices) to Octagon Healthcare. Furthermore, given the bad deal struck over the project initially and made worse under the refinancing arrangements, it might seem odd that it could still be worthwhile to buy out the contract. This is until it is realised that, given the rent of the building (an average over the past six years of £29.4 a year in 2007 prices) and the first break point in the contract (in the year 2037), the amount payable over the next 28 years (from now, 2009, to 2037) is £823 million (again at 2007 prices).

It is, of course, not the case that the savings from the buy-out would be as large as £823 million. This is because the liabilities of the Octagon Healthcare Group Limited have to be bought out, and bought out immediately whereas the savings from the rent would only be realised year-by-year over the next 28 years. Therefore the rent payable has to be discounted to a 'present value' to allow for the fact that money today is worth more than money tomorrow. Then Octagon's liabilities need to be deducted from this 'present value'.

The discount rate that it seems sensible to use is the discount rate used by the UK Treasury, namely 3.5 per cent per annum. Over 28 years, the cumulative discount factor at 3.5 per cent per annum is about 17.6. Thus the present value of the saving in rent between now and 2037 would amount to £29.4 million multiplied by 17.6 equals £517 million.

What would the NNUH have to pay to Octagon Healthcare? According to figure 4 on page 11 of the report of the Committee of Public Accounts (PAC, 2006), the amount payable now - in 2009 - would be about £300 million. It is clear that buying out the contract now would

save the NHS (and therefore the Government and taxpayer) about £217 million (the £517 million saving in rent, as discounted, minus the £300 million of Octagon's liabilities).

Therefore in spite of having already spent £197 million in rent for the hospital and in spite of having to buy out £300 million of Octagon Healthcare's liabilities, the taxpayer would still save £217 million by buying out the NNUH contract. This is for a hospital the basic construction cost of which in the late-1990s was £158 million. All of which goes to show what an appalling waste of money the PFI contract has been.

Furthermore it is important to note that the saving in the rent may not be the only saving that can be made by buying out the Octagon contract. If the contract is bought out, there may also be savings in building maintenance and service costs (catering, portering, etc) plus savings from not having to buy more expensive treatment from private hospitals in the region if, following the buy-out, more wards were built at the NNUH.

Therefore my recommendation is that the Government should buy out the PFI contract at the NNUH and then expand the NNUH by as much as 100 beds. The latter would mean that not only would treatment no longer have to be purchased at higher unit cost from private hospitals in the region but also that the NNUH would reduce its very high occupancy rates. Efficiency and staff morale would both be improved.

Buying out other PFI hospital contracts?

If there is a case for buying out the NNUH contract, there may be a case for buying out the PFI contracts at other hospitals.

On the one hand, the case for others being bought out is likely to be weaker insofar as the NNUH was an exceptionally bad PFI deal. For example in its report on the NNUH refinancing, the National Audit

Office pointed out that "although the Trust has received a share of the refinancing gains, it continues to pay a premium on the financing costs compared to current deals" (NAO, June 2005, 3).

On the other hand, other buy-backs might be equally attractive, given that other PFI hospital schemes are more recent than the NNUH and therefore there are likely to be more years of rent to save. Furthermore, as noted above, because of the refinancing arrangements at the NNUH, the liabilities of Octagon Healthcare were increased so that the cost of buying out the contract may very well be higher at NNUH than at other PFI hospitals.

Therefore buying out PFI hospital contracts may well generate large expenditure savings for the Government. Of course it is hardly likely that the Gordon Brown government will buy them out. Such a u-turn is unlikely. But, at the very least, future PFI programmes should be cut back so as to avoid even higher costs in the future.



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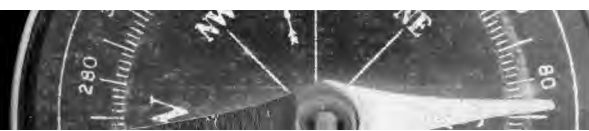
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End Notes

- 1 Chris Edwards is a senior Fellow at the University of East Anglia. This article is based on a research report of about 100 pages. This will be published before the end of March 2009. Some detailed figures are omitted to keep this article short. Any queries can be directed to Chris at c.edwards4@btinternet.com
- 2 This information is from Hansard, written answers, 15 December 2008, Column 458W – website publications/parliament/UK - accessed on December 31 2008. For more information on expenditure on health care in the UK see ONS, April 2008 and Wanless et al., 2007.
- 3 P Edwards is no relation of this author.
- 4 This assumes that the payments of £180.7 billion are spread fairly evenly over the 30 years, but slightly changing the pattern would make little difference to the calculations.
- 5 A model devised by Andersen, the consultancy company, in a report for the Treasury in 2000 (Andersen et al, 2000)
- 6 These comparisons have been summarised in reports by Andersen and by the National Audit Office
- 7 The other shareholders with their shares as at the end of December 2007 were: 3i Infrastructure Seed Assets GP Limited (26.3 per cent); John Laing Social Infrastructure Limited (21.1 per cent); and Trillium PP Investment Partners Limited (26.3 per cent).
- 8 Some prominent New Labour politicians are also no doubt relaxed about PFI. Thus Alan Milburn was Secretary of State for Health between 1999 to 2003 where he actively promoted PFI and then became a £30,000 pa adviser to Bridgepoint, a venture capital firm heavily involved in financing private health care firms moving into the NHS (see Pollock et al 2004, 6)
- 9 The Southern Norfolk Primary Care Trust no longer exists following the reorganisation of the Primary Care Trusts in February 2008. The Norfolk Primary Care trust was formed from five former PCTs.



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