

THE PRIVATE FINANCE INITIATIVE AND THE MARKET FOR “LEMONS”

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INTRODUCTION

The Private Finance Initiative (PFI) has become the main source of capital funds for new investments in the UK National Health Service (NHS). Following a long teething process under the 1992-1997 Conservative government when, despite strenuous efforts, not a single major PFI deal was signed in the NHS, the Labour government has enthusiastically adopted the PFI and is now using it to fund successive waves of hospital construction.

The PFI has been subject to many criticisms. However, the key issue in determining whether a PFI funded scheme will be more cost-effective than a similar scheme funded in the conventional way by the Exchequer rests on the relative private and public sector costs of capital and the allocation of risk between parties. This paper considers the evidence for a differential between private and public sector costs of capital in the case of NHS projects; discusses the application to the NHS of different theoretical arguments about whether private sector capital costs more than public sector capital; and suggests that private sector perception of an information asymmetry may be having an impact.

THE PRIVATE FINANCE INITIATIVE

Before 1992, direct financing by the private sector of capital investment in the NHS had been negligible.¹ There was some leasing of assets from private firms but this was minimal. The Treasury's rules governing the appraisal of public sector investments made it practically impossible to demonstrate value for money where so-called “unconventional finance” was proposed. The fact that Exchequer funds might not be available for a more cost-effective “conventionally financed” option was not deemed relevant by the Treasury.

Government policy on this matter changed fundamentally in 1992, however. In his 12 November Autumn Statement, the Chancellor of the Exchequer announced a relaxation of these rules.² From then on, government ministers took to extolling the virtues of private finance for public assets. The 'Private Finance Initiative' (PFI) was born. Encouraging the use of private finance, developed in November 1994 into a requirement that PFI options be tested fully for any proposed public sector capital scheme. Public sector bodies, including the NHS, wishing to undertake significant capital projects were to assume that they would be privately financed. But schemes would still be subject to formal appraisal and approval and would have to demonstrate 'value for money'. Only if private finance were not available at reasonable cost might Exchequer funds be forthcoming, but they might quite possibly not be, in which case the public body would have to go back to the drawing board.

In a major conventionally-financed NHS capital project, such as building and equipping a new hospital wing, the design of the required facility would have been undertaken by NHS staff, consulting with professional advisers as required. Construction of buildings would be put out to competitive tender by the NHS Trust to private construction firms. Equipment would be procured in a similar way. The funds to pay the chosen contractor would have been borrowed from the Exchequer and interest on that debt paid to the Treasury. In addition, once the capital project was complete and the contractor paid off, the NHS Trust was required to demonstrate that it was earning a six per cent rate of return on the totality of its assets, including those newly constructed.

With a PFI scheme, however, the design of facilities is left largely to the bidding private consortia, who would typically be required to offer to build and finance the project. They are also expected to provide the non-clinical services necessary to run the building once complete. In return the consortium receives payments spread over a long period of years, typically 25 or 30. Variations on this standard DBFO (design, build, finance and operate) approach are possible, but this has been the predominant model hitherto.

The government's view since 1992 has been that the PFI will improve value for money in the provision of public services through:

“better allocation of risk; better incentives to perform; close integration of service needs with design and construction; a clearer focus of responsibilities of public and private sectors which more clearly reflects the strengths of each; a continuing commercial incentive for efficiency throughout the design, asset creation and operation of the project; and more potential for efficiencies.”³

The House of Commons Treasury Committee, while still generally supportive of the PFI, was notably more measured than this, offering the view that “many of the assumed benefits of PFI would appear to be available to better managed and controlled conventional procurement”.⁴

In 1997, the new Labour government took up the PFI with enthusiasm. It describes the aims of this policy in words indistinguishable from those of its Conservative predecessor. Thus the new Chancellor of the Exchequer stated in November 1997:

“Through the Private Finance Initiative, the private sector is able to bring a wide range of managerial, commercial and creative skills to the provision of public services, offering potentially huge benefits for the Government.”⁵

No mention is made in this or other official statements of the investment capital that the private sector also contributes, along with its skills, when it contracts to provide a PFI scheme for the public sector. It is interesting to contrast this with the views of NHS managers seeking PFI-funded capital investments in their Trusts. The author’s experience is that they give high billing to the PFI’s ability to bring them large capital sums for newly building or substantially refurbishing their hospital; sums on a scale that would simply not be available from the Exchequer. This is reflected in the tendency for the PFI to dominate when large capital sums are sought. See Table 1.

Table 1: Capital Values of Major* NHS PFI Schemes Signed up to 31/10/98

Scheme	£ million
Dartford and Gravesham Hospital	115
Carlisle Hospital	63
South Buckinghamshire	39
Norfolk and Norwich Hospital	214
North Durham Hospital	96
Hairmyres Hospital, Lanarkshire	68
Law Hospital, Lanarkshire	100
Greenwich Hospital	84
Wythenshawe Hospital, South Manchester**	66
Royal Infirmary of Edinburgh	180
TOTAL PFI	1,025

Sources: HM Treasury, Department of Health and Scottish Office press releases during 1997 and 1998.

Notes: * Schemes with a capital value equal to £25 million or more. The PFI is also being used to fund smaller capital schemes but is less significant there than Exchequer finance.

** The total capital value of this scheme is £113 million, the balance being funded by the Exchequer.

The current government has relaxed its predecessor's requirement of PFI or nothing for NHS (and other public sector) schemes. Exchequer finance is now back on the agenda as an option. However, the criteria for determining when it might be made available have not been made explicit and the PFI approach is still promoted as the government's preferred route for achieving NHS capital investment. The PFI currently provides more than 70% of capital finance for major NHS investments. Over the UK as a whole, the 10 major NHS PFI deals for which contracts had been signed by 31 October 1998 (all of them signed since May 1997) had a total capital value of £1,025 million (see Table 1).

Over the same period, seven major Exchequer-financed schemes were approved, with a total capital value of £393 million. In respect of major schemes whose full business cases have been approved, the story remains similar. Some further publicly funded developments are envisaged but rather fewer than the further PFI schemes that are on the stocks.

(For smaller schemes, with capital values below £25 million, Exchequer financing remains the principal source of capital. As a result, a large amount of Exchequer funded capital expenditure still goes on in the NHS: a planned £1.5 billion⁶ (including reinvested receipts from sales of surplus NHS assets) in England in 1998/99, but this is spread across a very large number of relatively small-scale investments.)

HOW BENEFICIAL CAN THE PFI BE IN THE NHS?

To set against the expected benefits of the PFI which are listed in government statements, a range of arguments has been presented to suggest that there are substantial disbenefits which also need to be taken account of. For instance, it has been argued that the PFI distorts investment priorities in the NHS by focusing on large new acute hospitals, which the private sector appears interested in, rather than small schemes more suitable for primary, community and mental health care services, or refurbishment-based schemes which make use of existing assets. Health service planning is replaced by doing what and where the private sector is most willing to finance.⁷ Others have pointed to the large costs that are incurred by both the NHS and the private sector bidders in complying with the PFI process. Furthermore, this selection/bidding and contract negotiation process takes months, or even years, longer than the procurement process for Exchequer-financed schemes. This needs to be set against any claimed advantages of quicker completion for PFI construction projects once they do get under way.⁸

In this paper, however, I concentrate on the narrow comparison between a worthwhile and fully defined (i.e. signed) PFI scheme and an equivalent publicly-funded alternative. Within that comparison, the focus is on the relative cost of private and public sector capital and the impact on it of risk and uncertainty. So as not to divert attention from this main topic, the (debatable) political question of whether the Exchequer would actually fund a scheme if that were to be demonstrably more cost-effective than to follow the PFI route, is put aside.

NHS PFI projects contain the following main elements of private sector input:

- design, construction and equipping of the new facility;
- provision of non-clinical services for the duration of the contract (typically 25 or 30 years);
- (usually) disposal of some surplus NHS assets;
- provision of finance for the capital investment.

To be of net benefit relative to a conventionally funded scheme (the ‘public sector comparator’ in the jargon), a PFI project must yield lower costs and/or greater benefits in one or more of these four areas. In considering the extent to which that is possible, the following points should be remembered.

First, NHS hospitals have always been built and equipped by the private sector, the successful contractor being selected via competitive tender. These construction contracts have routinely contained penalty clauses for poor performance or late completion. Therefore, it is only through having (possibly) greater freedom to design the facility that a PFI consortium can hope to better the conventional approach. The extent to which this freedom exists depends on how well the Trust is able to specify what it wants without saying what that means in terms of the physical scale and lay-out of the required hospital. However, health service professionals generally have firm ideas about the latter, in contrast to most private consortia which, at least at present, have little experience of designing hospitals to fit NHS models of care.

Second, non-clinical services have been subject to competitive tendering in the NHS for many years now. In most Trusts, more than one round of competitive tendering will already have been completed for each of the main non-clinical services: catering, cleaning, laundry, security and car parking, etc. A PFI bidder may, therefore, be hard put to find significant further efficiencies in these services.

Third, the private sector may be attracted by the possibility of obtaining surplus hospital land at the Trust to develop for housing or some other remunerative purpose. However, the value of this development potential in excess of what the Trust would realise if it simply sold the surplus assets on the open market, should be close to zero. The fact that it happens also to be building a hospital for the land’s previous owner is unlikely to enable a firm to extract any additional value from a site.

In the light of these three considerations, the question of whether private borrowing costs more than public becomes vital to the ability of PFI schemes to be as cost effective as a conventionally financed project.

The cost of finance within the overall charge made by the private consortium to the NHS is not publicly available for any PFI scheme. Heald (1997) was moved to comment: “The Treasury cannot or will not quantify the additional financing costs consequent upon financing by private finance rather than by government borrowing, or quantify the interest rate differential. Given the confidentiality which attaches to loan arrangements, systematic evidence about the additional cost of private finance can only be produced by the Treasury or, with a considerable time lag, the National Audit Office”.⁹

Indications are, however, that the private sector’s cost of borrowing significantly exceeds the public sector’s. In the Heald article quoted in the preceding paragraph, reference is made to a 1991 Government Economic Service Working Paper¹⁰ which concludes that bond finance for large private sector bodies typically costs up to a percentage point more than public borrowing. However, finance for NHS PFI schemes is predominantly project-specific, so that the rates may be less favourable than for bonds backed by the full resources of a large corporation.¹¹ Thus the private sector cost of capital will be considerably more than one percentage point above the cost of public capital. The Treasury Select Committee observed in 1996 that private finance for PFI schemes (in all areas, not solely the NHS) “may require a premium of 6-9 percentage points above the gilt rate”.¹² Glaister, in evidence to the same Committee, agreed that private finance costs more than public and concluded that, to be successful, PFI schemes would have to offer off-sets to this in-built cost disadvantage.

The findings of Pollock et al.¹³ are also interesting in this context. They noted that major PFI schemes were assuming exceptionally large reductions in the required bed capacities of the hospitals concerned. There may be very good reasons for some or all of these planned reductions, such as expectations of increased day case rates, shorter lengths of inpatient stay and increased bed occupancy rates. However, Pollock et al. noted that the PFI schemes were based on lower projections of demand growth, greater reductions in lengths of stay and higher

levels of occupancy, than national trends would imply. A new hospital might enable more efficient use of beds than an old one, but it is unclear how this could be of more than marginal magnitude. An alternative interpretation is that the size of PFI hospitals is being squeezed to fit what the Trust (i.e. its purchasers) can afford within their cash limited budgets. The evidence is very circumstantial but is consistent with an attempt to scale down the cost of the bricks and mortar relative to what would be planned conventionally, in order to leave more room for the cost of capital, because private sector finance costs more than Exchequer finance.

This interpretation is supported by (unattributable) conversations I have had over the last few years with a range of NHS managers and their management consultant advisers who have been involved in NHS PFI schemes. A recurring view is that a conventionally financed scheme would be preferable were it available but that there are no Exchequer funds to be had for large new capital schemes in the NHS. Faced with the choice of continuing with the existing facilities or going for a new but smaller (in order to be affordable within the fixed budget available to the local health care purchasers) PFI-funded hospital, it is easy to select the latter with a clear conscience. Demonstrating on paper the ‘cost effectiveness’ of this choice relative to a hypothetical public sector comparator, in order to satisfy official ‘value for money’ and audit requirements, then requires only a little ingenuity.

Therefore, in all probability, the capital raised to finance PFI projects in the NHS costs significantly more than would public borrowing to finance the same project. The next section considers the possible explanations for this.

THE COST OF BORROWING: PRIVATE VERSUS PUBLIC

Before the launch of the PFI late in 1992, official Treasury guidance stressed that:

“The government is generally able to finance activities more cheaply than individual agents in the private sector mainly because it is, from the perspective of the financial markets, a good debtor. It has the unique power to tax and its risks are spread over a

wide range of activity. The transactions costs of government financing are also low and the market in government debt is liquid and efficient. The government is therefore able to borrow at very attractive terms.”¹⁴

This quote is taken from (Annex F, para.5 of) the 1991 version of the so-called Treasury ‘Green Book’ or, to give it its more formal title: *Economic Appraisal in Central Government: a Technical Guide for Government Departments*. Interestingly, the latest version of this Treasury guide, published in 1997 in the new pro-PFI political world, omits the paragraph quoted above. Furthermore, it makes no mention whatsoever of the relative costs of public and private borrowing. The argument has not been changed; it has simply been ignored.¹⁵

The earlier Treasury view had taken on something of the status of a received wisdom. Thus, to take just one example among many, Heald and Geaughan (1997) felt safe to conclude that “because the Treasury can borrow more cheaply than a private borrower, recourse to private finance must bring with it savings in terms of capital and/or operating costs to be more cost-effective than a publicly financed project”.¹⁶

An opposing view exists, however, which, while recognising that the rate of interest to be paid on government borrowing is lower than that on private borrowing for similar projects, argues that this is because the public sector cost of capital hides the true cost of risk, which the private sector makes explicit. Klein (1997) puts the view very clearly that public borrowing only *appears* cheaper because the government is able to coerce taxpayers into meeting the cost of downside risks should they materialise:

“If taxpayers were remunerated for the risk they assume in the case of tax-financed projects, then ex ante there would be no capital cost advantage to government finance. The risk premium on government finance would, in principle, be no different from that of private investors. There is thus no justification on the basis of capital cost advantage, for government funding or guaranteeing the provision of private goods or services.”¹⁷

Grout and Flemming and Mayer in other articles in the same Winter 1997 issue of the *Oxford Review of Economic Policy* make reference to this same argument.¹⁸ Flemming and Mayer even refer to it as “the current orthodoxy”. Indeed, the Treasury, in its 1991 version of the ‘Green Book’, recognised that “public financing costs do not reflect the risks of individual projects” (Annex F, para.6).¹⁹ But does this matter in the context of NHS PFI investments?

In their seminal 1970 article,²⁰ Arrow and Lind demonstrated that, in a world characterised by the existence of perfect markets for claims contingent on states of the world, the government would be justified in acting as risk neutral: i.e. in making investment decisions on the basis of expected net present values using a risk-free discount rate. Given that the real world is *not* so characterised, they then went further and showed that, in any case:

“when the risks associated with a public investment are publicly borne, the total cost of risk-bearing is insignificant and, therefore, the government should ignore uncertainty in evaluating public investments. Similarly, the choice of the rate of discount should in this case be independent of considerations of risk. This result is obtained not because the government is able to pool investments but because the government distributes the risk associated with any investment among a large number of people. It is the risk-spreading aspect of government investment that is essential to this result.” (p.366)

Arrow and Lind’s result depends on there being sufficient taxpayers, and on the public investment being small enough relative to the total income of taxpayers, such that the cost risk borne by each taxpayer is a negligible component of their income. Their result also depends on the returns from the public investment in question being independent of the other components of national income.

This argument for risk-neutrality applies not only to government but also to large corporations, provided that they effectively have a very large number of shareholders, to whom the cost risk is a small part of their income. But Arrow and Lind suggested two reasons why large corporate lenders might nonetheless behave as risk averse and so demand a risk premium within the cost of their lending:

1. one or a few shareholders may have large percentages of the corporation's stock, sufficient both to exercise some control over its investment decisions and also to make the cost risk associated with an investment non-trivial relative to their income;
2. corporate managers whose careers and incomes are linked to the firm's performance, may be risk averse and so discount for risk.

Critics of this view point out that with modern, global capital markets the risk borne by any individual lender is as negligible as the risk borne by an individual taxpayer as a result of government investment in a project. They would also point out that public sector managers may well want to be risk averse when making investment decisions: their careers will not be helped by a failed project either. So the true cost of capital, taking appropriate account of the risks attached to a particular investment, should be the same whether the source of the capital is the Exchequer or the private sector according to this argument.

The second of the two criticisms set out in the preceding paragraph does not seem relevant in the NHS. Firstly, the success of an Exchequer funded hospital investment is not determined by its ability to earn income but by its ability to satisfy the acute health care needs of its local population, within the budget available. Secondly, the demand from NHS managers for major capital investments in their hospitals has always greatly exceeded the capital funding available to pay for them. With persistent, severe quantity rationing of NHS capital, the risk averse simply do not put project proposals forward.

The first criticism may or may not have validity. Its resolution is essentially an empirical question. The problem is that, even if it is assumed that private capital markets can spread risk as thinly as the government, the private cost of capital for NHS hospital investments is evidently higher than the public cost, and this cannot be because of systematic risk in those investments, because there is practically none. The sums paid by an NHS Trust to a PFI contractor over the life of the contract depend on the hospital continuing in use and this is about as independent of the state of the rest of the economy or the stockmarket as it is possible to get. (Note that the same may not be true of other types of public sector PFI

investments, such as transport infrastructure, the returns to which may indeed be dependent on the rest of the economy). Investment in providing and operating a public hospital would appear to be a safe, acyclical prospect. So why does this additional private sector cost of capital persist? A possible explanation is considered in the next section.

NHS PFI: A MARKET FOR “LEMONS”?

The argument in the previous section assumed that capital markets work, at least to the extent that the observed cost of private sector capital for an NHS PFI project would be a fair reflection of the risk involved. However, if an information asymmetry exists then, even if in all other respects private capital markets are operating efficiently, private sector capital might still be unduly costly relative to Exchequer borrowing. Put another way: the private sector may be charging too high a cost of capital because, due to ignorance of important information, it is unduly pessimistic about its future returns from NHS PFI contracts.

Whether or not NHS managers know more than the private sector about the future demand and supply factors affecting hospitals in the UK, the private sector consortia and their financiers appear to believe that they do. Thus, PFI bidders act as if an information asymmetry exists. For the following discussion, the existence of this perception is as important as whether such an information asymmetry really does exist.

The private sector will, for a consideration, readily take on risks with which it is familiar. In the government's view, it is such risk transfer which is the main source of the hoped for value for money in PFI. However, it seems that private sector financiers view long term investment in the NHS to be a risky and unfamiliar proposition. How can they be sure that the local Health Authority, or the NHS Executive, or even the Department of Health will not decide in a few years time that they do not need a particular hospital any more, or at least not all of it?

High profile cases like the recent saga of Guy's Hospital's "Phase III" may have stoked this fear. In that particular case, a £152 million²¹ capital development at a famous teaching hospital in a prominent location near the River Thames, on the opposite bank from the City of

London and its capital markets, was on the brink of being scaled down and left as a relative backwater before it had even been finished. The latest plans to safeguard hospital activity on the Guy's site, given the go-ahead by the government in summer 1998, might help restore the City's confidence in the NHS as a place to invest but some lasting damage may have been done.

Furthermore, the only hospital within the City of London, St Bartholomew's, happened to be the most prominent victim of the last government's plans to rationalise London's high cost hospital services. It has lost its Accident and Emergency Department and is having the scale and scope of its activities much reduced. The new Labour government's plan to "save" Barts as a specialist cancer and cardiac centre, rather than in its previous role as a full scale teaching hospital, may not be sufficient to quell City fears that hospitals are risky places to sink large sums of capital.

The Audit Commission makes explicit reference to private lenders' fears:

"Financiers may well be new to the public sector and uncertain about its legal powers and decision-making processes. A high degree of caution may be fuelled by past legal decisions involving public bodies where banks suffered large losses."

This appears to be a reference primarily to the London Borough of Hammersmith and Fulham "swaps" scandal of the 1980s, where millions of pounds owed to banks as a result of losses on financial transactions by local authority officials were left unpaid because the officials were judged by the courts to have been acting *ultra vires*.

Whatever the precise history, it is clear that capital markets are nervous of being caught out by the NHS and by future government intervention. After all, potential private lenders to PFI consortia may suppose that the government has the opportunity to exert arbitrary influence over too many of the factors relevant to the future of an NHS hospital, such as: the level of NHS funding overall, investments in other hospitals and other health care facilities nearby, changing health care policy away from hospital-based care, and so on. It would then take a

lot of trust not only in the current but also in future governments (PFI contracts typically last 25-30 years) to sink £100 million into a new NHS hospital.

The reality of this lack of trust in government is evident from the fact that it took a special Act of Parliament, the July 1997 NHS (Private Finance) Act, stating that NHS Trusts would not be ultra vires in signing up to PFI contracts, before the first major NHS PFI deal could be signed. The Dartford and Gravesham scheme (see Table 1) was signed on 30 July 1997, a fortnight after the Act was passed.

It is therefore arguable that the premium cost of capital that is being paid to get NHS PFI schemes signed up, relative to the cost of Exchequer finance, is the price of overcoming this lack of trust. That is, it would indeed be less costly to fund NHS capital investment from the Exchequer but the government apparently deems the extra cost of the PFI to be worth paying in order to achieve other policy goals. There is a considerable literature discussing what the underlying purpose of the PFI might really be - largely focused on the question of the way that PFI-finance assets are scored in the government's national accounts, i.e. whether their creation represents private or public expenditure - but this lies beyond the scope of the present article.

Without this government willingness to pay over the odds in order to persuade the private sector to lend money to the NHS to build hospitals with, the NHS PFI market would come to resemble Akerlof's 'market for "lemons"'. In his famous 1970 *Quarterly Journal of Economics* article,²² Akerlof demonstrated how ignorance by purchasers of the quality of what they were buying, e.g. second hand cars, would lead them to assume that what a supplier was offering was below the quality of the best available. The price that buyers would be willing to pay would accordingly be too low to persuade potential suppliers of good quality second hand cars to part with them. As consumers, through collective experience gradually learned that the best cars were no longer on offer, they would revise down their expectation of the quality of any particular second hand car that was still available for sale. Thus a vicious, self-fulfilling circle would be created, which would ultimately ensure that only low quality cars ("lemons" in American English vernacular) would be available on the market, albeit at correspondingly low prices. Good quality cars would (literally) be driven away from the

market because of customers' inability to identify them and hence their unwillingness to pay the commensurate price.

Perhaps the PFI consortia, and particularly their financial backers, are in the position of being offered by the NHS a range of investment opportunities promising future income streams but they are unable to detect with confidence the quality of those income streams. They see that, occasionally, hospitals are wholly or partially closed even when they have relatively recently been the recipient of major capital investment. They cannot tell whether this will happen to the hospital they are being invited to invest in and they do not wholly believe government ministers', civil servants' and NHS managers' assurances that there is nothing to be worried about. So they assume that there is a non-zero risk that the contracted income stream will be less than promised. They therefore require a premium in the contract payments they demand in return for designing, building, financing and operating the hospital. If the NHS were then to withdraw from the PFI those schemes which could, burdened by this private sector premium, be achieved at lower cost with Exchequer funding, then it would be fulfilling the private sector's worst fears. Only the relatively high risk projects, likely to be shut down or reduced in scale before the end of the contract period, would then be, from the NHS's perspective, cost-effective to finance via the PFI.

In summary, if potential private lenders to PFI consortia believe that they lack some information, which the NHS or government holds, about the future prospects of a hospital scheme, it is then inevitable that private finance will cost more than Exchequer finance. The private sector cost of capital will include a premium for the risk they perceive, even if that exaggerates the true level of risk associated with a project.

POLICY IMPLICATIONS

If the proposition described in the preceding section is true, then the policy implication is either that the government should act to remove the information asymmetry (which is much easier to write than to achieve), or that it should rely on Exchequer finance for NHS capital

investment. If neither of these options is pursued, it has to be recognised that taxpayers' money is being wasted.

Removing the information asymmetry that is perceived by the private capital market means that private lenders must believe that the NHS has revealed all of the information it has about the possible future prospects for any scheme. Presumably, statements to this effect are already being made, but they appear not to be fully believed.

Private lenders will presumably eventually gain confidence by the time that a few major NHS PFI schemes have been up and running for several years without mishap. But we may have to wait many years before the fear of being left with stranded assets subsides. Perhaps an information programme demonstrating the longevity of past major investments in the NHS might help to soothe some brows? The age of most buildings on the NHS asset register is well over 30 years (the typical length of a PFI contract), for example. But, more to the point, can the government demonstrate that no major hospital facility built in the last 30 years has been partially or completely closed?

To avoid the impression that it might be indulging in some cherry-picking - keeping the best/safest projects for the Exchequer to finance - the government should make explicit the criteria according to which NHS capital schemes are selected as being suitable for Exchequer finance rather than being PFI-ed. This needs to be backed by published audits carried out by respected bodies (such as the National Audit Office or the Audit Commission) which demonstrate for each major Exchequer-funded scheme of how it fulfils those criteria.

A market response to try and overcome information asymmetry might be to attempt to build up brands with reputations for good quality, or to seek third parties willing to license or otherwise endorse products as being good. However, when the NHS, i.e. the government, is the supplier, it is hard to see how these approaches could help. Whose endorsement would be deemed valid?

However, another common market mechanism for overcoming information asymmetry is more feasible. That is where the suppliers offer guarantees of the type promising

“satisfaction or your money back”. In the NHS PFI case, this effectively means a government guarantee that if a PFI-provided asset becomes redundant, then the government will ensure that the owner of the asset is not left out of pocket. That, on the face of it, sounds reasonable. It is no different from the position that the taxpayer faces when an Exchequer-funded asset becomes redundant. Taxpayers have paid for something that turned out to be less valuable than was originally expected, so they end up bearing a cost. Furthermore, the influence that a private consortium providing only non-clinical services has on the factors determining whether a hospital is to close or scale down, is minimal.

However, the government has been reluctant to pursue this option, as it would mean admitting explicitly that the government was bearing the demand risk associated with the investment. Such an admission dents the impression being encouraged by the government that the PFI is benefiting taxpayers by enabling the NHS to transfer risks to the private sector. However, in July 1998 there was a sign that this reluctance was weakening: the Secretary of State for Health provided a “letter of support” for the Greenwich Hospital PFI deal just prior to its being signed. The Financial Times of 9 July 1998 reported that this letter “provided bondholders with ‘additional comfort’”.

This change in government willingness to guarantee (or “support”) may prove temporary, however, as a result of the Accounting Standards Board’s (ASB’s) September 1998 pronouncement on the accounting treatment of PFI deals,²³ with which the Treasury is apparently going to comply for all PFI deals closed from 1 January 1999 onwards.²⁴ The ASB amendment to its ‘Financial Reporting Standard 5’ means that the admission that the NHS continues to bear the demand risk associated with an asset will now bring a further disadvantage in the government’s eyes. It should mean that such PFI assets will henceforth be recorded on the public sector balance sheet and hence that the expenditure on them will be recorded as adding to the public sector borrowing requirement (PSBR). But that is another story.

Perhaps it should simply be recognised that the PFI will remain a second best option relative to conventional Exchequer finance in the NHS. For there the PFI consortium is operating in a market devoid of third party payers. Effectively the only paying customer is the government

itself. Where there are real customers independent of government and its agencies. e.g. where there are motorists wishing to use a toll bridge or privatised railway companies wishing to benefit from an investment in improved signalling, private financiers may feel comfortable with taking on long-term investments in specialised assets. But where the private consortium's future income stream appears to them to be subject too much to the discretion of government agencies, they will inevitably seek a premium price.

¹ Charitable donations of equipment, buildings, and even land, have long been an important feature of the NHS. They are not the subject of this article, however.

² The peculiar history of these rules and of the policy changes surrounding them is set out concisely in: Heald D (1997), Privately Financed Capital in Public Services. *The Manchester School of Economic and Social Studies*, Vol.LXV, No.5, December 1997, Oxford, Blackwell.

³ Private Finance Panel (1995), *Private Opportunity, Public Benefit*. Private Finance Panel, November 1995.

⁴ Paragraph 33 of: House of Commons Treasury Committee (1996), *Session 1995-96, Sixth Report, 'The Private Finance Initiative'*, HC 146. The Stationery Office, London.

⁵ From the foreword to: Treasury Taskforce: Private Finance (1997), *Partnerships for Prosperity - the Private Finance Initiative*. HM Treasury, November 1997.

⁶ According to the government's July 1998 report of its Comprehensive Spending Review, total Exchequer investment of capital in the NHS in England, including receipts from sales of NHS assets, is planned to rise from £1,544 million in 1998/99 to £2,220 in 2001/02.

⁷ See for example: Boyle S (1997), The Private Finance Initiative Undermines Rational Planning of Health Services. *BMJ*, 314 (7089), 26 April 1997, pp.1214-1215; Dawson D, Maynard A (1996), Private Finance for the Public Good? *BMJ*, 1996, Vol.313, 10 August 1996, p.312; and Gaffney D, Pollock AM (1997), *Can the NHS afford the Private Finance Initiative?* BMA Health Policy and Economic Research Unit, December 1997. The Audit Commission in its 1998 Management Paper, *Taking the Initiative: a Framework for Purchasing under the Private Finance Initiative*, also warns that it is "important to be aware that some schemes may be more attractive to the private sector than others - for example, because of their larger size. These schemes may not, however, be the highest priority for the public sector" (para.19).

⁸ Dawson D, Maynard A (1996), Private Finance for the Public Good? *BMJ*, 1996, Vol.313, 10 August 1996, p.312.

⁹ Heald D (1997), Privately Financed Capital in Public Services. *The Manchester School of Economic and Social Studies*, Vol.LXV, No.5, December 1997, Oxford, Blackwell.

¹⁰ Melliss C (1991), *On a Puzzle of Returns to Physical and Financial Assets in the UK Company Sector 1965-1987*. Government Economic Service Working Paper No.114, HM Treasury, London.

¹¹ Hitherto, much PFI finance has been raised by special purpose vehicles - consortia specifically put together to provide a particular PFI hospital scheme - with no recourse to the (considerably greater) assets of the parent companies in the event of financial problems with the scheme itself. The Greenwich Hospital scheme, signed in July 1998, is largely bond financed but that bond is drawn solely on the private consortium's income stream from the NHS Trust; it is not backed by any other assets.

¹² House of Commons Treasury Committee (1996), *Session 1995-96, Sixth Report, 'The Private Finance Initiative'*, HC 146. The Stationery Office, London.

¹³ Pollock A, Dunnigan M, Gaffney D, Macfarlane A, Azeem Majeed F (1997), What Happens when the Private Sector Plans Hospital Services for the NHS: Three Case Studies under the Private Finance Initiative. *BMJ*, 314 (7089), 26 April 1997, pp.1266-1271.

¹⁴ HM Treasury (1991), *Economic Appraisal in Central Government: a Technical Guide for Government Departments*. HMSO, London, April 1991.

¹⁵ HM Treasury (1997), *"The Green Book". Appraisal and Evaluation in Central Government*. Treasury Guidance, The Stationery Office, London.

¹⁶ Heald D, Geaughan N (1997), Accounting for the Private Finance Initiative. *Public Money and Management*. 17(3), July-September 1997, pp.11-16; here p.11.

¹⁷ Klein M (1997), The Risk Premium for Evaluating Public Projects. *Oxford Review of Economic Policy*, Vol.13, No.4, Winter 1997, pp.29-42; here p.29.

¹⁸ Grout PA (1997). The Economics of the Private Finance Initiative. *Oxford Review of Economic Policy*. Vol.13, No.4, Winter 1997, pp.53-66; and Flemming J, Mayer C (1997), The Assessment: Public-Sector Investment, *Oxford Review of Economic Policy*, Vol.13, No.4, Winter 1997, pp.1-11.

¹⁹ HM Treasury (1991), *Economic Appraisal in Central Government: a Technical Guide for Government Departments*. HMSO, London, April 1991.

²⁰ Arrow K, Lind RC (1970), Uncertainty and the Evaluation of Public Investment Decisions. *American Economic Review*, 60, June 1970, pp.364-378.

²¹ Department of Health Press Release 98/228, 9 June 1998, Frank Dobson Welcomes New Era of Hospital Construction.

²² Akerlof GA (1970), The Market for "Lemons": Quality Uncertainty and the Market Mechanism. *Quarterly Journal of Economics*, Vol.89, August 1970, pp.488-500.

²³ Accounting Standards Board (1998), *Amendment to FRS 5 'Reporting the Substance of Transactions': Private Finance Initiative and Similar Contracts*. Accounting Standards Board, September 1998.

²⁴ Treasury Taskforce Private Finance Projects Team (1998), Press Release 146/98, 'Geoffrey Robinson Welcomes Accounting Clarification of PFI'. HM Treasury, 10 September 1998.