Public services and the private sector

A response to the IPPR

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November 2001

revised with a new foreword by David Hinchliffe MP

A CATALYST WORKING PAPER

Published in November 2001 by

Catalyst
PO Box 27477
London SW9 8WT

Telephone 020 7733 2111
email catalyst@catalyst-trust.co.uk
www.catalyst-trust.co.uk

ISBN 0 9533224 7 5

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Foreword

By David Hinchliffe MP,
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Labour was elected to a second term of office with a clear manifesto commitment to reform and rebuild Britain s public services. There can be no disagreement about the importance of this task, nor about the strength of the popular mandate that demands it. The question, of course, is one of means. Some have suggested that opening the way to greater private sector involvement in both the financing and delivery of public services may provide the answers. This important and timely publication suggests that this may be a dangerous road to go down.

The debate over the relationship between public services and the private sector is not a new one. In the case of health, it is one of the great unresolved issues that has plagued the NHS since its inception, as the principles of equity which inspired its foundation are still today frustrated and undermined by the encroaching presence of an appeased private sector. While the majority must wait sometimes unconscionable lengths of time to see an NHS consultant, a minority who can afford it are able to queue-jump by visiting the same consultant at his or her private practice. The wisdom of focusing on waiting-list reduction targets has been much debated of late, but from an ethical point of view there is no more perverse distortion of priorities than this treatment of those who can pay more before those with greater clinical need.

Moreover, there is nothing new or untested about the idea of using the private sector to make up for alleged shortcomings in the public. We have been here already, and seen the consequences. In my time as chair of the House of Commons Health Select Committee I have seen the effect of Tory policies deliberately designed to facilitate the expansion of private medical insurance, and private sector provision in areas such as mental health and long term care, pioneering the process that it is now proposed we extend to the heart of our health care services. The Committee has been unanimous in its concern over the private sector s abysmal record in quality of provision, and the way its constant draining of publicly-trained staff out of the NHS obstructs the development of better services within the public sector. I have come to the conclusion that we need to bring about a complete separation of the NHS from the private sector, for the sake of preserving and developing the system of collectivised health care that the vast majority of the British public remain deeply committed to.

This paper by some of the leading experts in the field of public services and

government finance draws on experiences in the area of health care and elsewhere to examine the case now being made for expanded private sector involvement in public service delivery. The authors point to widespread evidence, at home and abroad, that service quality and efficiency is likely to deteriorate as private operators cut corners and distort priorities to increase their margins. They show how talk of value for money, risk transfer and contract transparency can be just so much hot air in the real world where fragmented and under-resourced public agencies are forced by stringent fiscal constraints into long-term dependency on powerful private sector providers.

Most seriously, they suggest that despite the protests of some advocates to the contrary, the principle of comprehensive services free at the point of delivery *is* at issue here. At the same time as ring-fencing increasing proportions of tax revenue as charges to be paid to the private sector for decades to come, PFI and PPP deals put private operators in a perfect position to market their services as top-ups to core services whose quality and scope must be threatened by this constant drain on public resources.

In my own view, the key to reforming the public sector is not the profit motive, but democracy and accountability. We have never had a democratic national health service, and one of the reasons that patients sometimes misuse the service — by not turning up for appointments, for example — is that they lack a feeling of personal ownership in it. We need to make the system of NHS governance far more open, involving patients in decisions about how it is run. This could also provide part of the solution to some of the clinical failures uncovered at the Bristol Royal Infirmary and elsewhere — public involvement in and scrutiny of the health service could pick up some of the concerns that are known among professionals, nursing staff and managers, but without a brave whistleblower may never see the light of day.

The redesign and reconstruction of public services that will meet the challenges and demands of the twenty-first century is the most pressing political, social, and moral issue facing us today. Clear, informative, and authoritative, this pamphlet is essential reading for anyone who hopes to find their way in this vital debate. The Health Select Committee will be conducting a thorough investigation into the relationship between the private sector and the NHS, and I m pleased to see that we have here already an important contribution to our inquiry.

Executive summary

1. Introduction

- This paper argues that the IPPR makes its case for extending PPPs into core public services by downplaying evidence of their cost and efficacy, and ignoring the context in which they operate.

2. Financing public services

- There is no economic or fiscal case for PFI and PPPs, but the Treasury continues to force public agencies down the private route.
- Value-for-money claims depend on competition, private sector efficiency, and risk transfer, none of which are substantiated in practice.
- PFIs and PPPs are effectively ringfencing ever enlarging proportions of public revenue as payments guaranteed to private corporations for decades to come.

3. Private vs public: the evidence

- Research in the US and Australia shows that for-profit status significantly and adversely effects service outcomes in terms of cost, quality, and efficiency.
- The IPPR presents no evidence to demonstrate that private sector involvement in prisons and social services has led to an improvement in service quality.
- Private management of hospitals in Australia has been fraught with difficulties.

4. When contracts fail

- Analysis shows that once a project is up and running contractual relations do not necessarily follow the legal form. The public sector has frequently forgone its legal entitlement to penalty payments for poor performance in the interest of building relationships and due to the lack of a realistic alternative supplier.

5. Undermining universal provision: PFI in the NHS

- PFI is downsizing the NHS to subsidise the private sector by raiding capital budgets, reducing hospital beds, and raiding budgets for clinical care.
- The NHS Plan puts in place mechanisms for NHS bodies to redefine free health care and introduce user charges for personal care.

6. Conclusion

- No country in the world has delivered universal public services on the back of for-profit providers. The costs are too high, the risks are too great and markets are not and cannot be oriented toward social equity goals.

1
Introduction

The Commission on Public Private Partnerships, conducted over the past two years by the Institute for Public Policy Research (IPPR), was set up to introduce greater clarity to partnership arrangements between the public and private sectors and produce a set of authoritative guidelines which will inform the use of partnership in the future . It is expected to be an important influence on the government s approach to public service reform in the years ahead.

When the Commission s long-awaited final Report (1) appeared, attention focused on the sharp criticisms it made of the way the Private Finance Initiative (PFI) and Public Private Partnerships (PPPs) had operated in the past (3). A number of important problems were identified including poor value-for-money, the higher costs of PFI, the failure to deliver promised innovation in design and organisation, and the political considerations that were forcing agencies into partnership routes.

Nevertheless, the Report goes on to recommend and extension of these new forms of procurement, including the extension of PPPs into core services such as health, education and local government (4). The Commission s main criticism of the government is of its failure to adequately justify its PFI/PPP policy (5), and it declares that its own role is to do just that — clarifying the potential role of a diverse range of partnerships in improving value-for-money, securing greater social equity, increasing the scope for community and user participation and guaranteeing that all public service providers are responsive to the changing needs of the citizens who rely on them (6). As such, it provides valuable support for the government s determination that there should be no no-go areas of the public sector for partnership arrangements (7).

The purpose of this response is to highlight some of the external realities that affect partnership arrangements, and financial issues and implications of these new forms of public procurement, that the IPPR has either ignored or downplayed. We argue, on the basis of domestic and international evidence, that the ongoing proliferation of partnership arrangements across our public services is draining public revenues, compromising the range and quality of services provided, and ultimately threatening to undermine the very principle of universal services free at the point of use.

2

Financing public services

Under the partnership rubric are included a range of different relationships with the private sector: long-term outsourcing contracts; joint ventures; strategic partnerships; PFIs or design, build, finance and operate schemes; etc (8). The essential point is that the services will be provided by the private sector and/or the voluntary sector, but funded and regulated by the public sector.

The public agencies pay for the infrastructure used to deliver the services and the services themselves via an annual charge that consists of two elements: the availability or rental that covers the capital costs (construction, interest charges and life cycle maintenance costs); and the Facilities Management (FM) fee that covers the costs of service provision. Some partnership arrangements may only require an FM fee. These distinctions are important for considering the impact on public finances.

PFI/PPP is a form of borrowing, not funding, that shifts the burden onto future generations. As the IPPR acknowledges, the public sector repays the full cost of the private sector providing the infrastructure and services in annual payments over periods of 20 to 30 years. It does not access new forms or higher levels of funding than would otherwise be the case with public funding (9). Like buying a house on a mortgage, it simply spreads the cost of repayment over a long period and like mortgages costs considerably more than paying up front. Thus any additional costs, problems and deficiencies will fall on future taxpayers and users.

The Treasury could have fully funded new investment without any recourse to public debt. The IPPR report confirms that there is no justification for using private finance in terms of public sector borrowing — all PFI capital spending over the period 1999-2002 could have been replaced by normal public sector capital spending financed through the traditional method of selling government bonds or gilts without breaking the either the golden rule or sustainable investment rule (10). But more than this, the current account surpluses of recent years (£23bn for 2000-01 alone) could have covered the £14bn of PFI capital investment deals signed between 1997 and 2001. Since the Treasury could have funded considerably more capital investment without borrowing a penny, the present generation of taxpayers could have funded new infrastructure for both the present and future generations instead of shifting the burden of interest payments onto future generations. The IPPR does not acknowledge that such investment could in effect have been provided free .

The IPPR claim that PPPs do not represent more than a relatively modest fraction of overall public spending (11) cannot be verified. The figures they use are misleading. Many PFI/PPP deals include land sales, transfer of assets and capital grants from the public sector. Thus while the value of the deals show the estimated size of the capital element to be financed by the private sector, they exclude the public sector s contribution. Generally, the land sales and asset transfers have been arranged on very advantageous terms to the private sector. To take but one example: the Royal Edinburgh Infirmary sold the 70 acres of land released by concentrating facilities on a new greenfield site in Edinburgh for about £12m to a subsidiary of one of the PFI partners. The total capital cost of the hospital that has a 20-25 per cent lower capacity is about £180m. A market price for the land would have paid one third of the cost. But this in turn means that the real cost of the deal is about £240m. Most other deals involve similar arrangements that understate the total cost of PFI.

The National Audit Office (NAO) is examining the whole issue of land sales. Neither the spending departments nor the Treasury provide data on the volume of capital subsidies, grants and receipts from land sales which contribute to PFI investment. Thus the claim that PFI/PPP deals are a small proportion of total capital expenditure is unsubstantiated. And many more deals are in the pipeline. The truth is that we simply do not know the real proportion.

There is no alternative. It is not true to say that there is a level playing field when considering PFI/PPP (12). The government continues to force public agencies down the partnership route (13). In many cases, adequate public funding is simply not available and public agencies are forced to pursue larger schemes that are more attractive to the private sector. Examples exist in the NHS (Walsgrave and Swindon & Marlborough) of refurbishment schemes for thirty-year-old hospitals in favour of new builds. Similarly in education (Pimlico school) and London Underground. This is deliberate government policy. To take but one example, in its 1998 Comprehensive Spending Review, the government announced funding specifically to improve school facilities and standards *through Public Private Partnerships* (emphasis added) (14). Thus the playing field slopes sharply downhill on the private side when public agencies are considering the relative merits of PFI/PPP and conventional public funding. In practice public agencies are often forced to rig the public/private comparisons to ensure approval for schemes that will only be funded under partnership arrangements. This in turn means that PFI/PPP must increase as a proportion of government expenditure.

There are few bidders in practice. The IPPR repeats the mantra that competitive pressures between the bidders (contestability) will result in value-for-money for the public sector (15). The reality is that there are few bidders and most should be or indeed are rejected on the basis of capability alone, leaving the public sector with little choice in practice. In such situations, the private sector has the public agency over a barrel. Furthermore, when the contract needs to be renegotiated because changes are needed or the outsourcing contract comes to an end, the contractor is in a very powerful position.

Value-for-money through greater private sector efficiency is elusive. One of the key arguments used in promoting PPPs is the supposedly greater managerial skills of the private sector that will result in greater efficiency and economy (16). The IPPR buys into this uncritically. Yet good evidence on this is lacking (17).

Indeed such a claim flies in the face of the ever declining economic position of British manufacturing, and the all too obvious impact of cost-cutting for service delivery and the long-term viability of infrastructure industries such as water and rail. More importantly, such claims ignore the specifics and history of most public services, which are labour-intensive, with much of the existing workforce already poorly paid. This plus twenty-five years of cash limits, efficiency savings and huge productivity increases means that there is little fat that can be trimmed. Cost comparisons with other industrialized countries show that our public services are cheap. Our own analysis of public and private health care provision shows that further efficiency gains can only be made by excluding the more expensive/skilled services and jettisoning the notion of a comprehensive and universal health care system free at the point of use.

In promoting the extension of partnerships, the IPPR fails to acknowledge that in practice most of the comparisons of public vs private procurement implicitly recognise the inability to improve efficiency, since most such comparisons depend upon risk transfer to show value-for-money (18). Increasingly this is also the primary way in which local authorities and central government justify PPPs.

Value-for-money through risk transfer may be illusory. Risk transfer and risk estimation is problematic for several reasons. Firstly, the methodology for assessing the value of the risk to be transferred is highly subjective. Secondly it only considers risk to the commissioning agency and not to the wider public sector agencies that may be affected by failure. Neither does it consider the risk to the users. There are additional risks posed by outsourcing the delivery of essential services, often for the most vulnerable within the community for whom

there are no alternatives. But this in turn means that the value-for-money comparisons are of very limited use in determining whether to go ahead with a scheme, as the NAO report into the London Underground PPP confirmed (19).

Thirdly, the IPPR ignores the fact that while it is possible to list the risks on an *ex ante* basis, it is far from easy to ensure that the estimated risks are transferred in practice via the contract. Even when they have been contractually transferred, it is not always possible to enforce the contract for a range of practical reasons. The recent debacles over the IT PFI contracts, which the IPPR specifically excluded from its investigation of PFI/PPP, left the public sector and service users bearing the costs. Most the evidence that purports to show the efficiency savings and risk transfer under PFI rest upon the infamous Contributions Agency (NIRS2) and other failed schemes. In other words, they depend upon *ex ante* not *ex post facto* risk transfer. In the case of the Passport Agency, the additional costs were transferred to the travelling public in the form of higher charges. These issues are discussed at greater length in Part 4 below.

Further evidence about the low risk to the private sector comes from a number of sources. A number of projects have been able to re-finance their deals, saving themselves huge sums of money (20). The PFI consortia have advertised that their projects contain little inherent risk and been able to raise bonds on a triple A rating, the best (21). Several major firms have sold off their construction arms in order to concentrate on PFI/PPP, which they say are less risky.

The IPPR, like most commentators, concentrates on value-for-money (whole life costs of the project including risk transfer) to the exclusion of affordability at the unit level. Like domestic and household purchases, it is quite easy to demonstrate value-for-money. We have all done it. It depends upon what is included/excluded, priorities, how the costs are counted and over what period. But, crucially, projects may be value-for-money but unaffordable. Where different options for investment are being compared, the scheme showing better value-for-money can be less affordable than the alternative, as has been shown in the case of the Cheshire Police Authority scheme (22). They can also be both poor value-for-money and unaffordable.

Schemes may be pruned to make them affordable or extra public resources thrown at them. Hence the land sales, asset transfers, capital grants, capacity and service reductions so prominent in hospitals, schools and other projects such as the Passport Agency s IT system (23). Income may have to be diverted from other sources to bridge the revenue gap.

In the case of local authority schemes, the government makes available up to 75 per cent of the capital cost of the deal, leaving the local authorities 17-25 years down the line with the problem of where to make the cuts. None of the business cases we have examined show how the affordability gap is to be bridged (24). Neither has there been any publicity about this shortfall in funding. Which services will be raided to pay for it?

In the case of schools, while the local authority receives about 75 per cent of the capital cost from government, it is the schools that have to pay the FM fee. Yet they are not party to the deal and the local authority does not consider this in the business case. In the cases we have examined, the implications for the schools budgets are far from clear. But the point is that any increase in cost over and above what is currently paid can only be at the expense of the teaching budget. On the other hand, if the LEA picks up the tab, then it is at the expense of other local schools.

In practice, staff will have to work harder to meet challenging productivity targets and quality of service will decline, with cuts in the more expensive services, and charges for some services, in order to balance the books.

These new forms of public procurement now account for the majority of annually managed public expenditure. The IPPR makes no mention of the extent to which these new forms of public procurement, including outsourcing, have grown. In 1977, when most public services were carried out in house, general government purchase of external goods and services (gas, electricity, office supplies etc) accounted for 28 per cent of annually managed current expenditure (ie., excluding welfare payments and debt servicing). By 1991, it had risen to 38 per cent and in 1999, the last year for which data is available, to 57 per cent. In other words, the turn to outsourcing, which the IPPR proposes to expand via partnerships, already accounts for more than half annually managed expenditure. In contrast, internal costs or wage costs have declined from 72 per cent in 1977 to 38 per cent in 1999.

Estimated annual payments for only the signed PFI deals range from £2.9bn in 2000-01, to £4.5bn between 2004 and 2008, thereafter declining to £4bn as some schemes come to an end or change their payment profile. Since these payments largely relate to new deals rather than replacement of existing outsourcing arrangements, then the money available to pay for them is what remains of public expenditure after paying for the purchase of existing goods and services — the declining wage budget. Annual payments will therefore divert about 6-7 per cent

of the current wage bill, and this is set to increase quite dramatically as new deals are signed.

The point is that more and more of the current budget will be committed, leaving less and less to the discretion of the public agencies and reducing flexibility. Furthermore, since the PFI/PPP payments have first call on public finances, any future public expenditure cuts, efficiency savings or increases in prices charged by the contractors will be at the expense of those services that remain in house . De facto, the giant corporations that carry out these contracts will more and more come to control public expenditure and public policy. In schools alone, which all the FM companies see as their main growth area, the market is expected to be worth £5bn a year — a sum equal to 20 per cent of the current wages bill in the total education (which also includes further and higher education) sector.

In effect the annual charges will be a hypothecated tax. Most public services have never been universally provided anywhere in the world on a commercial basis because it was impossible to charge and collect payment from the user at the point of use. In other words, the risks were too high for the private sector. Indeed, they are provided nowadays precisely because of popular unrest in an earlier period at the lack of such provision. Today the IPPR, on behalf of the private corporations, proposes to claw back those concessions, providing the services on a commercial basis with the government ensuring a guaranteed income stream, via the taxpayer.

Under PFI/PPP and these new forms of procurement, the government guarantees to collect tax from its citizens on behalf of the private sector over the next 20-30 years. But there is no such guarantee to protect public services such as health and education.

3

Public vs private: the evidence

The IPPR Commission is concerned that government policy on partnerships should be informed not by ideology but by evidence. We are ... clear that government should base its decisions on evidence rather than a predisposition towards using partnership agreements as a way of delivering public services (25). Unfortunately, however, the IPPR does not appear to have used the available evidence to reach its conclusions.

Provider status and motivation — why it matters

The IPPR attempts to reduce the difference in motivation between the public and private sector to an irrelevance. It states that the role of each sector should be assessed on their ability to bring about specific service outcomes (rather than on their legal structure or their public, private or voluntary sector status) (26).

The IPPR cites one piece of as yet unpublished evidence, which it says demonstrates that for-profit operators in care services for the elderly do not always place profit maximisation above other values such as professionalism or empathy (27). This research is inconclusive. Other research conducted by the Personal Social Services Research Unit (PSSRU) demonstrates that operators do prioritise income or profit particularly when the motivation of large corporate providers is examined — understandably, given their responsibilities in respect of shareholders (28).

Provider status and motivation is important. The public and private sectors are motivated and orientated towards two different sets of goals. Put simply:

- the private sector has moral obligations to investors that take priority over social obligation to customers (29)
- the public sector is motivated towards social responsibility and environmental awareness (30)

The evidence presented below demonstrates that for-profit operators of hospitals

- provide lower quality of care than publicly managed hospitals
- have higher administration costs than publicly managed hospitals
- provide more expensive and inappropriate treatment than publicly managed hospitals
- are technically and allocatively less efficient than publicly managed hospitals

For-profit nursing homes provide lower quality of care than publicly managed nursing homes. An analysis of the 13,941 nursing homes in the US (31) found that for-profit owned (investor) nursing homes provide worse care and less nursing care than not-for-profit or public homes. Investor-owned facilities averaged 6.70 deficiencies (measured against quality of care and quality of life) per home. This figure was found to be 29.8 per cent higher than not-for-profit homes and 25.2 per cent higher than public facilities.

A further study by the same authors also noted that smaller facilities with fewer beds were less likely to have quality of life and quality of care deficiencies than larger facilities. This is important for the UK where the size of the facility is linked to the status of the provider. The mean home size for large corporate providers of care homes was 54 beds substantially larger than elsewhere. The mean size for local authority run homes was 35 beds and 30 beds in not-for-profit residential homes (32).

For-profit hospitals have higher administration costs than publicly managed hospitals. A study into the relative administrative costs within hospitals with different provider status (33) found that for-profit hospitals spend 23 per cent more on administration than do comparable private not-for-profit hospitals and 34 per cent more than public hospitals. For-profit hospitals also have higher total costs per inpatient day and per discharge.

Table 1
Administrative costs as a percentage of total hospital costs (US)

Private for-profit	34%
Private not-for-profit	24.5%
Public hospitals	22.9%

Source: Woolhandler, S, and Himelstein, D, (1997).

The evidence for high administrative costs within the private for-profit operation of hospitals can also be found in Australia. For overhead costs (ie. administration) private hospital costs were 31 per cent more than public hospital costs. (34)

In contrast, the UK NHS is one of the most efficient health care systems in the world, spending less than 12 per cent as a whole on administration costs. This

cost has increased from 6 per cent with the introduction of the internal market — the ratio between nurses and administrative staff fell from 3.5:1 in 1981 to 2:5.1 in 1996. (35)

For-profit hospitals provide more expensive and inappropriate treatment than publicly managed hospitals. A study by Stephen Duckett and Terri Jackson assessed the arguments that the private sector is more efficient than the public sector (36). They concluded that in the case of provision of hospital services the public sector is in fact more technically, allocatively and dynamically efficient than the private sector. Based on a comparison of the cost of each separation (ie. each episode of care) they found that public hospital costs were significantly lower than private hospital costs.

Table 2

Estimated average cost per weighted separation, public hospital casemix, financial year 1996-97

	Average cost per separation adjusted for discrepant elements
Public hospital costs	AU$1,774
Private hospital costs	AU$1,941

Note: Discrepant elements removed are public medical, pathology, imaging and pharmacy costs and depreciation costs for the private sector. Costings use national public hospital DRG cost weightings
Source: Duckett, SJ, & Jackson, TJ, (2000)

The Centre for Health Program Evaluation in Australia also examined the relative cost of care between private and public hospitals (37). They compared the likelihood of patients receiving a costly high technology procedure after hospitalisation due to an acute myocardial infarction (AMI). The likelihood of a patient receiving a costly form of treatment or a costly procedure was found to be between 100 per cent and 400 per cent higher for patients admitted to private hospitals. This raises questions of the appropriateness of care that patients receive in private hospitals. They concluded that:

- data suggests that private hospitals may be more likely to employ costly procedures and that the unit costs of such procedures may be significantly greater in the private sector

- private hospital care may cost the public sector more than public care
- these results imply that the expansion of private hospitals and the privatisation of public hospitals may significantly increase the cost of health care

To conclude, then, the use of the private sector to deliver health care shows it to be technically and allocatively less efficient than the public sector. Evidence also shows that provider status has a demonstrable impact on the quality of care that is provided within hospitals.

Benefits of the private sector?

The IPPR authors ask, If private and voluntary sector providers have long been established in social care and are playing a greater role in the provision of prisons should they be restricted from playing a greater role in health or education? (38) However there is no evidence presented in their report to show that the private management of prisons and residential care services for the elderly has achieved anything other than a reduction in cost.

In the prison sector the IPPR provides no evidence to show that the private operation of prisons has led to an improvement in service quality. All the evidence demonstrates that savings have been made as a result of a reduction in staff terms and conditions.

- Costs per prisoner in four privately managed prisons in 1997—98 were 11 per cent lower on average than in comparable publicly managed prisons and *staff costs accounted for all of this difference* (emphasis added) (39)
- The most important element of labour cost savings was reduced staff hours per prisoner, accounting for a third of the total. However, some of this appeared to reflect higher levels of crowding in privately managed prisons rather than the increased use of labour saving technology, improved systems management and the efficient allocation of staff to key tasks. (40)
- Of the total labour cost savings achieved by privately managed prisons, approximately *two thirds* appear to represent a *reduction* in the aggregate pay, benefits and conditions of the workforce (emphasis added) (41).

The IPPR states that the quality of privately managed prisons — as measured by the Prison Service s Key Performance Indicators (KPI) is very similar to that of publicly managed institutions . But it concedes that there is no evidence to

suggest that the private sector is capable of out-performing the public sector in two of the four privately managed prisons used for the comparison above, the private contractor subsequently lost out to an in-house prison service team. (42)

The IPPR report provides no evidence to show that the use of private sector organisations to deliver care services for the elderly has led to an increase in the quality of care that it is delivered. While there is ample evidence to demonstrate that purchasing social services for the elderly from the independent sector has led to a reduction in the cost of the service (43) the impact on the quality of care is rarely measured. What is known about the use of the independent sector is that most of the savings and efficiencies which have occurred have come about at the expense of staffing cost and thus potentially the quality of care.

- A review commissioned for the South and East Economic Development Strategy found that The shift from in-house to independent provision has been inextricably linked to reductions in pay and conditions for people delivering care (44)
- The PSSRU has noted that local authorities fear that in seeking to drive down costs they might also drive down quality, and our evidence from providers suggests that this has indeed been the result (45)
- Private nursing and residential homes generally pay lower wage rates than local authority homes (the majority of private care home providers were paying less than £4 per hour) (46)
- Data provided by Laing and Buisson shows that the attempt to drive down costs in the delivery of residential and nursing care services for the elderly has led to the closure of 700 independent care homes each year for the past two years
- High staff turnover within independent sector residential care homes has a detrimental impact on the quality of care (47)

Private hospital management

The IPPR recommends that the operational element of a PFI hospital should not be limited to the provision of ancillary services and the inclusion of a wider range of services should be an option for purchasing bodies (48). However the operation of this type of scheme in practice has been far from successful.

The experience in Australia demonstrates that the private management of public hospitals is fraught with problems and difficulties. It has led a Committee of the

Australian Parliament to recommend that: No further privatisation of public hospitals should occur until a thorough national investigation is conducted and that some advantage for patients can be demonstrated for this mode of delivery of services . (49)

The model of private hospital management which appears to be recommended by the IPPR is similar to that in operation in Australia. Unlike the Private Finance Initiative in the UK, the Australian model has not been restricted to the provision of ancillary services within hospitals but incorporates the full range of clinical services. However, this particular model has led to three specific problems:

- state governments have taken on additional risks in contracting with private companies for the management of public hospitals
- state governments have been forced to increase payment to the private operators in order to reverse their financial losses and to keep them in business
- private sector operators have ended contracts for health provision when partnership arrangements become unprofitable. The government remains the provider of last resort.

The following case studies illustrate some of the additional risks of private hospital management.

Hidden risks: Joondalup Health Campus, Western Australia
In 1997 the Western Australian Auditor General examined the contract between the state government and a private contractor for the management of a public hospital (50). Amongst other things the Auditor general found that there were serious limitations of the quality standards employed within the contract. The ability of the government to prevent the private operator from engaging in opportunistic behaviour was also found to be lacking. The Auditor s report notes:

- the contract may not prove effective in ensuring desired service quality
- it is possible for the Operator to seek to limit the quantity of services provided where the Operator considers it not to be in its commercial interest
- in order to minimise operational costs there is a risk that the Operator might seek to discharge some patients inappropriately early
- there was the potential within the contract for the Operator to maximise its income through the incorrect coding of treatments. This would result in overpayments by the state government

In summary the Auditor General concluded that the government had taken on additional risks as a result of the shift from public to private provision, including:

- limited contractual control over the quality of services
- financial incentives for the Operator to influence admission, treatment and discharge patterns
- potential overpayments because of incorrect coding of treatments

A la Railtrack?: Modbury Hospital, South Australia

The Modbury Hospital gives an example of where public authorities are forced to ensure that private companies remain profitable in order to maintain service provision. In 1995 the South Australian Government signed a contract with Healthscope Ltd to manage the Modbury Public Hospital for a period of 10 years In 1997 Healthscope Ltd alleged that the contract price was insufficient to enable it to support the long term completion of the contract. Following this allegation the contract was substantially amended after the Government decided that it would be acting against the public interest in not amending the contract. It was estimated that the renegotiated contract reversed losses for the company of around AU$2m in 1996-7.

There still remain concerns about the extent to which Healthscope s financial concerns are impacting upon the key services that they provide. The Australian Nursing Federation reported that the Hospital s 24 hour emergency surgery service had been reduced with some services being provided by on-call services. The ANF (SA) stated that Healthscope had sought this as a cost saving device it since there was no drop in user rates of the service (51).

Important comparisons can be drawn here with the current problems which are occurring in the care home industry in the UK, with owners of care homes for the elderly threatening to evict residents unless their demands for higher fees are met (52).

When the private sector walks away: La Trobe Regional Hospital

There is the often unspoken consensus between public and private partners that government is expected to fulfil the policy responsibilities of failed private sector partners , Nicholas Lovrich has pointed out (53). An important lesson from the example given here is that whilst private sector operators can walk away from loss making contracts the public sector in its duty to citizens are obliged to maintain stable and continuous provision as the provider of last resort.

In 1996 a contract was signed between the Victorian state government and Australia Health Care Ltd (AHC) for the provision of a 257 bed public hospital. The hospital was to be owned and operated by the private company.

In February 2000 AHC alleged that the State Government had breached the contract relating to the LaTrobe Regional Hospitals and issued proceedings in the Supreme Court of Victoria seeking compensation. The AHC accused the State Government of refusing to honour its contractual obligation to pay appropriately for a range of services including mental health, child and adolescent community health, women s health and a suicide prevention programme. Whilst the AHC maintained that the court action was designed to maintain high quality health services standards it was also clear that the allegations were designed to protect the share holder interests. AHC, which operates 16 hospitals nationally made a total loss in 2000 of AU$79 million. LaTrobe hospital was the single biggest contributor to this loss.

On 31 October 2000 the LaTrobe Hospital was transferred back to the Victorian Government on 31 October. AHC had reported a loss of $6.2m in 1999 for the hospital. The Victorian Minister for Health stated that the losses incurred by Australian Hospital Care meant it could no longer guarantee the hospital s standard of care .

These experiences indicate that the model of private management of hospitals recommended by the IPPR is in practice fraught with difficulties. As well as there being no evidence to demonstrate that private management of public hospitals leads to greater efficiency there is substantial evidence to show that these types of partnership arrangements lead to difficulties in monitoring the quality of care. There is also evidence of governments being held to ransom over contract price. Further it is clear that a private operator will terminate a contractual arrangement when it becomes financially advantageous for it to do so. In these circumstances the public sector remains the provider of last resort. These issues are explored in greater depth in the next section.

4

When contracts fail

The IPPR calls for greater transparency and accountability in Public Private Partnerships (54). But by dealing with it in an abstract way, rather than examining specific cases and problems that have arisen, it makes some very general recommendations that do not address the wide range of issues raised, or show how this is to be achieved. The following case studies and conclusions are based on an analysis of some project failures. They are important because they raise concretely a range of issues about the outcomes of some of these new partnership arrangements which the IPPR has not addressed.

There is a lack of centrally available evidence about how well these new forms of procurement work and their wider implications. There is no register showing the range and size of contracts that have been signed, neither is there any means of evaluating or even finding what their outcomes have been in terms of both cost and service delivery. There is no information in the public domain about contract failures, penalties deducted from the payments, contract termination, etc. Indeed, many IT projects have failed without the public sector being able to either fine the contractor in ways commensurate with costs, or even terminate the contract. While it may sound straightforward to argue, as the IPPR does, that responsibilities, performance standards and penalties should be clearly spelt out, this is not so easy in practice, as the case of Railtrack demonstrates. In any event large, often international, corporations have far greater financial resources to dispute the legal contract than the now fragmented public agencies. In the final analysis the public agency is responsible for service delivery and will bear the economic, social, and political costs of failure. It is simply na ve and misleading to argue that contracting can be made to work in such circumstances.

Due to the fragmented nature of the public sector purchasers, it took a parliamentary question to reveal that over the previous three years private companies, contracted to provide support services to the NHS, including pharmacy and information technology, as well as ancillary services, had incurred more than £2m in fines triggered by failure to meet performance standards (55). The biggest group, just over one third of the 63 penalties over the period, involved hospital ancillary services. The penalties ranged from £520 for a security firm to £51,000 for a laundry contract. A further 10 contracts for support services — mainly cleaning and laundry — at hospital trusts were simply terminated due to failure to perform to time or to standard .

Another case cited in the same news story illustrates one reason for the lack of evidence — commercial confidentiality . Within three months of outsourcing its hospital laundry department, Basildon and Thurrock NHS Trust in Essex had to terminate the contract of a private cleaning company and in effect levied a fine of just under £300,000. The sum is believed to be one of the biggest penalties ever imposed upon a private supplier of NHS ancillary services. But for legal reasons, the Trust would not explain why it had cancelled the contract or even who the contractor was. The contractor likewise refused to discuss why the contract was cancelled. The Trust would only say that it withheld the cash because it was not meeting the contract requirements (56). This case was by no means unique. The new Freedom of Information Act specifically allows public agencies to withhold financial information relating to its outsourcing contracts on the grounds of commercial confidentiality . Consequently commercial confidentiality has been cited in a number of cases as the reason for refusing to divulge details when contracts have gone wrong.

Yet the investigations of the NAO have reported on the unsatisfactory state of hospital hygiene without mentioning the role that outsourcing may play in declining standards (57). In so far as outsourcing reduces hospital costs, it may do so by shunting the risks and costs elsewhere: onto patients and their families. This in turn means that the responsibility for this state of affairs is attributed to the hospitals, and not the contractors, and remedial measures may be misdirected.

The Public Health Laboratory Service

Following the outsourcing of all its accounting functions and financial management to CSL Ltd, a subsidiary of the global auditors, Deloitte and Touche, the Public Health Laboratory Service (PHLS) experienced a breakdown in its financial controls, and subsequent difficulties in operating its financial systems and preparing its accounts for 1998—99. This only came to public attention (in articles ten paragraphs long in the broadsheet newspapers) when the PHLS annual report was presented to Parliament. The NAO identified a litany of failures that could have led to error, fraud, and the mismanagement of public funds (58).

The key control weaknesses were very basic tasks: the failure to perform timely and complete bank reconciliations, and to keep accurate accounting records that was compounded by inadequate controls to prevent the misappropriation of funds and payments to fictitious creditors. By the year-end, more than £500,000 of receipts could not be matched against debts and many had been allocated

against the wrong debtor. There was a lack of credit control leading to an increase in bad debts. Once the PHLS realised that there were problems, it raised its concerns with the contractor, which then took some corrective action. The PHLS itself hired extra staff to deal with some of the problems. It also commissioned external accountants to undertake an extensive internal audit review of all its major financial systems managed by the contractor, and external consultants to manage the implementation of the project, leading to additional costs of about £300,000 and £471,000 respectively. While payments to the contractor were linked to their performance against a range of performance criteria, the performance measurements depended upon data provided by the contractor that were not available. Consequently, the payments reductions had to be negotiated outside the contract and totalled nearly £120,000, compared to the £615,000 actually paid. The NAO report did not comment on the disparity between the extra costs and the size of the reduction.

A number of inter-related issues arise. The first relates to how any failure is detected, reported and acted upon. This problem came to public attention via the audit due to the nature of the failure and the contract (financial management). Where the nature of the contract is crucial to the work of the agency and/or involves a significant financial outlay, the contract clearly needs to be included in the audit. But few will satisfy these criteria.

Secondly, value-for-money lies in an incentive-based payments scheme that penalises poor quality service. This in turn raises questions as to which party can or should supply the performance measurement data. In some cases, only the contractor can supply it. In this case, the contractor failed to deliver the performance indicators that would determine contractually whether the required standard of service had been delivered and the size of any financial penalties. While a reduction that was agreed by both parties to be a fair one was negotiated, such an outcome cannot always be assured. But even in this case, the reduction was less than the additional costs to the PHLS. The NAO report did not make an explicit evaluation or comment on the value-for-money implications of the project.

The NAO did acknowledge that the PHLS had sought to transfer the risks associated with systems implementation and the detailed operation of financial procedures to the contractor. But it concluded that while operational risk may be transferred, this does not affect the responsibilities of public sector managers for the proper management of its resources, a point we will return to later.
Another more fundamental concern arises: it is not always apparent by what mechanism good or bad performance will be detected, reported and acted upon.

For example, the PHLS problem came to public attention via the audit because the contract was financial management. In this instance the NAO was conducting a routine financial audit of the books of account and found errors that could have undermined the credibility of the reported figures. Consequently the auditors investigated the problem and checked the accounts to ensure that the published financial statements were satisfactory. The NAO s objective was not to establish whether the accounting system was value-for-money, only that it worked. In other circumstances, where the nature of the contract is crucial to the work of the agency and/or involves a significant financial outlay, the contract clearly will be included in the audit.

But a problem arises if it is small relative to overall income, because traditional audits of financial statements are only concerned with items that have a material affect on the published accounts. Also outsourcing fees are not listed separately as an expenditure item in the accounts, although PFI payments are. Furthermore it is unclear to what extent it is a function of the audit process to check the actual payments on an outsourcing or PFI/PPP contract against the contractual arrangements, which would provide some assurance of ex post facto value-for-money. Given that most contracts link the fee to performance measures, this would require the auditors to extend their role to a non-financial audit. Thus in the absence of an annual audit that includes a review of outsourcing and PFI/PPP and checks the independence, validity and accuracy of the performance indicators, it is difficult to see how value-for-money is to be ascertained. The NAO has argued that it needs access to private sector accounting records. While our analysis shows that this is indeed vital, there is a need for the annual audit to widen its role if *ex post facto* value-for-money is to be assured.

The Contributions Agency

By far the most well known failure of the IT projects procured under PFI has been the computer system for recording National Insurance contributions and making payments, known as NIRS2, that would handle more than 60 million records. The Contributions Agency, an Executive Agency of the Department of Social Security, let a PFI contract (NIRS2) to Andersen Consulting in February 1997 for a replacement for the National Insurance Recording System (NIRS1) to support the pensions payments system. It would develop the new system and operate it for seven years from April 1997, providing further enhancements by April 1999. Andersen Consulting secured the contract by bidding at £44m, £100m less than its original price, against other well known IT providers, as an essential loss

leader for the firm .

By December 1998, the Public Accounts Committee reported that the system was still not fully operational (59). Seven million items were waiting to be inputted, 17 million contributions to individual national insurance accounts had not been posted, and there were over 1,500 unresolved system problems, of which many were crucial to full implementation. Even by March 1999, 4.5 million items remained unposted. As a result, pensioners, widowers and benefit claimants have suffered uncertainty and loss of income. Thousands of benefits have had to be calculated on an interim or emergency basis, with over- and under-payments, resulting in the additional costs to the government of compensation payments to claimants. The subsequent integration of the Contributions Agency and the Inland Revenue meant that the Inland Revenue was unable to get details of records from the Contributions Agency s computer system. It thus lost an estimated 5.2 million records whose accounts have had to be closed with a consequent loss of billions of tax revenue for 1998-99 and further losses for 1999-00. Even in 2001, the system is not fully operational.

Anderson has paid a mere £3.9m in compensation for the delays. The Treasury Minister, Dawn Primarolo, admitted that the government would not demand compensation from Andersen for fear of damaging future relationships . When a public agency outsources its core business processes and problems develop, the purchaser can find itself at the mercy of its outsourcer, however strong their contracts. It illustrates once again that the costs of failure are borne throughout the public sector and by the public who are often, by virtue of the government s services, among the most vulnerable. The contract has clearly not proved to be value-for-money in the terms of the original business case.

The NIRS2 case is important not only because it is not unique, but because it was included in a widely cited survey of business cases used to demonstrate that PFI provides value-for-money (60). This report, commissioned by the Treasury from Arthur Andersen and Enterprise LSE, is particularly important. It shows that the *ex ante* case for PFI rested upon the transfer of risk in a handful of projects, and the NIRS2, which it did not explicitly identify, accounted for more than 80 per cent of the risk transfer. Thus its case for PFI largely disappears. These reports were particularly misleading because it was well known by then that the NIRS2 project had led to massive cost overruns.

The case also raises issues about the *ex ante* criterion of value-for-money. Despite the range of issues that purchaser must consider, because value-for-

money resolves itself into a single quantifiable score, as reflected in the net present value calculation, in practice it becomes the sole criterion for evaluating PFI proposals and bids. The Contributions Agency selected the cheapest option from a reputable firm that lowballed to get the contract in the hope of being able to use the software methodology on other contracts around the world. Thus the value-for-money criterion may itself lead to the wrong choice.

But the government drew a different conclusion. In 1999 the government announced, in response to several high profile IT failures where it was thought that the contractors had underbid, that companies bidding for contracts would now have to demonstrate that they would be able to make a profit. They would have to show the expected profits and the assumptions behind them before a deal was signed. The public sector in future will want to make sure that there is some profit in it for the private sector , said Andy Carty, the Information Technology specialist in the Treasury s PFI Taskforce. The public sector won t be allowing anyone any more to enter into a deal that does not show a profit for the private sector (61).

Housing Benefit projects

Other well-known outsourcing failures have been Housing Benefit payments systems. Many local authority housing departments contracted out the payment of Housing Benefits to well-known IT service providers, nearly all of whom ran into trouble on their contracts. In this section, we explain how the failure affected two councils.

In 1999, the **London Borough of Hackney** had 20,000 people with rent arrears and hundreds fearing eviction. Computer Weekly reported that up to thirty Housing Associations had threatened to boycott new tenants in Hackney because problems in the Housing Benefit (62). As the chief executive of the New Islington and Hackney Housing Association explained, this would lead to a severe financial crisis for Hackney Council. If Housing Associations refused to take homeless people put forward by the council, Hackney would have to put people into bed and breakfast accommodation at much greater expense. Its system had delayed payments for rent worth more than £1.5m. Hackney had been battling for more than a year with a raft of IT and business process problems on its IT outsourcing contracts.

In November 2000, Hackney was facing a deficit of about £40m for 2000-01, and a budget gap of least £50m for the following year, something unprecedented in

the modern history of local authorities, and announced a series of swinging cuts to its budget for the next three years. While an Audit Commission investigation into Hackney s governance noted that the performance of the revenue and benefits administration had been deteriorating, it did not mention the fact that these functions had been outsourced, and that the contractors had failed to deliver. Yet this was implicit in its recommendation that Hackney find alternative suppliers for these functions (63). It further recommended that Hackney s financial management be outsourced. In practice therefore, the absence of a public that is informed about the financial arrangements means that the failure of such projects is used to provide another example of public sector inefficiency , the very factor that outsourcing was supposed to eliminate. The remedy is yet more outsourcing.

The **London Borough of Lambeth**, which had let the Housing Benefit contract as a part of a block contract for other IT work to one contractor, Capita Business Services, was particularly badly affected. It had a backlog of 40,000 claims and a series of failed rectification programmes. But these failures have further implications for Lambeth s revenue collection illustrated when Capita wrote to a Lambeth council tenant to say, Your council tax benefit has been stopped from 17th April 2000 because there had been a change in your circumstances — the change is because you are dead. (64)

Although Lambeth was spending £1.5m to take back management control of the service, it had ruled out the option of exercising its legal right to make the contractor pick up the cost — because this could affect the contractor s work on the rest of the contract, which covers council tax, call centre and cashier services. The Council was legally in the position to suspend the benefits service from the contract and to provide or procure the service from elsewhere at Capita s expense , said a report presented to the Council s Policy Committee (65). Lambeth s Chief Executive doubted that it was operationally feasible. Capita is believed to be losing about £1m a year on the contract and is likely to resist the possibility of further losses . Implicit in this was the fear of a lengthy legal battle, which councils do not have either the human or financial resources to pursue. The Council said that the service implications are massive of Capita pulling out of Lambeth and brought into question the adequacy of a £5m performance bond held by the Borough.

Yet Lambeth s contract with Capita could not have been tighter. According to its legal advice, it could suspend the arrangement and provide or procure the service elsewhere at Capita s expense. Despite the contract s apparent power, it was all

but useless. The Council could not afford to dispense with Capita s services for several reasons: the time and cost involved in finding a new supplier and unravelling the control of processes that operate across departmental boundaries as Capita runs a range of Council services. Disruption of the relationship would lead to disruption of the service. Thus the Council found itself locked into a supplier whose activities were too closely interwoven with the Council s services. In other words, when problems developed, the public agency was at the mercy of its outsourcer, however strong their contracts. But the inability to terminate a contract for legal or operational reasons means that the ultimate sanction of contract termination does not exist, thereby depriving the purchaser of a mechanism for enforcing performance standards and ensuring value-for-money.

Conclusions

Our analysis shows that once the project is up and running contractual relations do not necessarily follow the legal form. Rather, the Contributions Agency and Housing Benefits cases show that the public sector has foregone its legal entitlement to penalty payments for poor performance and that the contracting is, to some extent, of the relational nature described in the private sector. Furthermore, the public sector may have borne the costs not only in the interest of building relationships but also due to lack of realistic alternative supplier that can be substituted for a poorly performing contractor.

The context of these large government IT contracts is also important. They are dealing with statutory services for which there is no alternative, and so the tasks typically require bespoke as opposed to off the shelf systems. The public sector must therefore deal with large, reputable organisations that are capable of providing the required service. Yet taken together this works against the public sector, which is effectively locked in to the contractor due to the size and importance of project. Also the criteria for terminating the contract may depend upon performance measurement that is so difficult to quantify that even where the possibility of penalties and termination exists, it may be impossible to implement these clauses in practice. But if the public agency cannot invoke these contractual clauses, then it has lost the ultimate sanction and may find it impossible to incentivise the contractor and deliver the promised value-for-money.

Part of the rhetoric of the new procurement policy is that value-for-money will be achieved by decentralising the decision-making process, thus enabling more efficient and appropriate local solutions than those proposed by remote

bureaucrats. In the cases we have examined this advantage is not really applicable to the Passport and Contributions Agencies since the services they provide are national and centralised. However, while the Housing Benefit scheme is one where local solutions might be relevant, in the two London boroughs it is not clear that local level decision making has in fact produced a better result than would have been available with traditional procurement. In essence this is not a testable hypothesis even where projects are deemed to be successful unless a comparison can be made with local authorities that did not outsource. In the final analysis, where the policy, in this case outsourcing, is a national one, local decision making is somewhat of a chimera: it relates simply how to implement it.

The government also closely linked the achievement of value-for-money to the transfer of risk out of the public sector, but this is far from straightforward for a number of reasons. In several cases, the contract failed to transfer the risk in the way the public agency expected. Where the contract did transfer risk, the ability to invoke the relevant clauses was affected by a locking in phenomena caused by the statutory or essential nature of the services involved and/or the desire to build long-term relationships. The Passport Agency case shows that contracts do not transfer management and thus political responsibility when things go wrong: the public and press hold the government responsible for failure to deliver passports on time. It was the Passport Agency, and its sponsoring department, the Home Office, not the private sector contractor, Siemens Business Services, that bore the brunt of public opprobrium (66).

The NAO s report into the PHLS reinforces this issue of management responsibility: responsibility for services rests with the public agency (67). The NAO did acknowledge that the PHLS had sought to transfer the risks associated with systems implementation and the detailed operation of financial procedures to the contractor. But it concluded that while operational risk may be transferred, this does not affect the responsibilities of public sector managers for the proper management of its resources. The NAO argued that potential risks needed to be identified, evaluated, mitigated and managed to ensure that these fundamental responsibilities continue to be discharged. This position may explain why the NAO failed to lay blame explicitly on the contract provider. The implication for the public agencies is that not only must they monitor and supervise the contract but also retain an in-house capacity, or an ability to bring in alternative suppliers, to provide the service in the event of any failure in service delivery. This means that an element should be included in the cost comparisons of the public and private procurement to take account of the additional risks and costs posed by outsourcing that most appraisals thus far have not included (and are not explicitly

required to provide). Given that the use of PFI/PPP largely turns on risk transfer, the decision to outsource would then be sensitive to such additional costs.

Apart from the additional cost of such back up facilities that would inevitably raise the cost of private procurement and hence reduce its value-for-money, there are legal issues. Many contracts contain clauses that explicitly limit the ability of the purchaser to carry out any of the work specified in the contract, unless the standards of performance fall below a certain level, which may itself be the subject of dispute, and/or prohibit the use of other outside contractors. Such considerations beg the question whether outsourcing of vital functions is indeed feasible.

Perhaps the most salient issue is that all the cases demonstrate what risk transfer really means. If we consider only the Passport Agency, it provides two examples of how risk transferred from the public sector to the public (68). First, since the agency must cover its costs by charging fees, any additional costs over those projected in the business case fell upon the public. Thus the travelling public bore the risk and cost of failure. The much vaunted risk transfer is not from the public body to the private sector, or even from the private back to the public sector, but onto the public as individuals. This is a travesty of risk transfer. Instead of pooling risks, risks are to be borne individually in a socially regressive way. The Passport Agency case also shows that in order to reduce waiting times short cuts were implemented that reduced security checks and this represents a security risk that had been secretly transferred to the public. The fact that these short cuts were rescinded once they became public suggests that there was no belief that the public was prepared to accept this risk.

Furthermore, as the media coverage of the Passport Agency debacle illustrates, while the queuing and delays were highly visible, these impacts, and indeed the project itself, were not necessarily the most important. The other cases had far more disastrous consequences, yet attracted far less attention. Indeed, the housing benefits problems attracted very little national news coverage despite the fact that tenants faced eviction for non-payment of rents, landlords went without income and refused to accept the homeless, and councils faced additional payments and costs thereby jeopardising their financial management.

5

Undermining universal provision: PFI in the NHS

In Part 1 we showed how fiscal policy and the creation of a new ringfenced PFI payment is a tax on public services and diverts both capital and revenue funds away from the public sector to the private sector. In this part we show the consequences of using private finance and the process by which NHS downsizing has occurred. We explain why it is likely that there will be charges for some elements of NHS care through rationing and through redefining some NHS care as personal responsibility.

On the basis of the evidence on PFI in health which is omitted from the IPPR Report we conclude that *PFI has failed to deliver affordable or appropriate hospital developments for the NHS in the 21st century*. The evidence shows that the use of PFI in hospitals has

- increased inflexibility and rigidity
- decreased diversity
- decreased access
- failed to meet public needs for health care (69)

The extra costs of the PFI are being borne directly by staff, patients and local communities with serious implications for access and for patient care. The high costs of PFI and the associated public service reductions make it likely that individuals will become increasingly responsible for paying for more elements of their care.

How PFI is downsizing the National Health Service

PFI is a tax on NHS clinical budgets. Unlike previous hospital building programmes, which were paid for out of a separate capital budget, PFI hospitals are largely paid for from the revenue budget, ie., the budgets that pay for patient care, clinical services, and staff salaries. For the first time in the history of the NHS, paying for capital is a local and not a national responsibility. The annual payment the NHS hospital makes to the private sector is known as the Unitary Charge, and comprises an Availability Fee covering the cost of construction, interest, and lifecycle costs; and a Facilities Management fee paying for services such as cleaning, lighting, and laundry. This is a new charge and comes from the clinical budgets for care.

The escalating costs of PFI are resulting in service closures. Part of the reason for service and bed closures across the NHS is cost escalation under the PFI. Compared with cost escalations of less than 8 per cent in the public sector, PFI hospital costs have more than doubled prior to financial close. This has led to a dramatic increase in the annual debt repayments required to pay for PFI.

Table 3

Cost of capital as a percentage of income, pre- and post-PFI

Trust	Pre-PFI Cost of capital as % of income	Post-PFI Cost of capital as % of projected income
Norfolk & Norwich	0.7	18.9
South Tees Acute Hospitals	3.9	10.0
Dartford & Gravesham	7.5	27.2
Greenwich Healthcare	3.7	13.3
Swindon & Marlborough	3.3	14.3
Bromley Hospitals	7.0	10.7
Calderdale Healthcare	3.0	11.3
North Durham Healthcare	2.9	9.9

Sources: Fitzhugh Directory (1999); Health Select Committee, (2000); NHS Trusts Annual Accounts, (1998-99), (1999-2000)

Table 3 shows that the new smaller replacement PFI hospitals are much more expensive than the replacement value of the larger hospitals they replace (70). The result has been to increase the costs of servicing the debts under PFI with the results that some trusts will now have to divert up to 19 per cent of their annual budget to pay for the increased costs of using private finance (71). Since 1991 NHS trusts have had to pay a charge on their capital which amounts to an average of 8 per cent. This increase in costs is paid for by service reductions.

Table 4

Changes in bed numbers at NHS Trusts under PFI development

Trust	1995-96	1996-97	Planned*
Bromley Hospitals	610	625	507
Calderdale Healthcare	797	772	553
Dartford & Gravesham	524	506	400
North Durham Acute Hospitals	665	597	454
Norfolk & Norwich	1120	1008	809
South Manchester	1342	1238	736
Worcester Royal Infirmary	697	699	390
South Buckinghamshire	745	732	535
Hereford Hospitals	397	384	250
Carlisle	506	507	465
Greenwich	660	566	484
Total	**8063**	**7634**	**5583**
Change (% change) from 1995-96	**—**	**429 (—5.2)**	**2542 (—30.8)**

Values are average numbers of beds available daily (all specialities)

* Private Finance Initiative beds are not directly comparable

Source: Pollock, A, et al, (1999) Planning the new NHS

As a result of these pressures the effect of PFI is to downsize NHS capacities in the following ways:

Raiding NHS capital budgets to create subsidies to the private sector

To offset the costs of PFI, the Treasury allows the NHS to use the funds released from land sales to offset the costs of PFI rather than reinvest in direct NHS provision. The Treasury has also made special funds available to the private sector to offset the costs of PFI, known as a smoothing mechanism . The Department of Health has also allowed regions to divert much needed capital funding away from the NHS into the private sector. All these subsidies to the private sector come from the public purse and usually result in the withdrawal of funds from other NHS services. This disinvestment in the NHS has seen the backlog in maintenance and repairs across the NHS rise to £3.1bn in 2001, hence and the current crisis in capacity.

Reducing hospital beds and hospital closures

To keep costs down the new hospitals have been downsized. New PFI hospitals schemes involve reductions in the number of acute NHS beds, many involve closures of other hospitals and services. The first fourteen PFI hospitals involve bed reductions averaging 33 per cent from outline business case stage but some schemes involve reductions of greater than 50 per cent. Since 1997 the NHS has closed 12,000 beds, many to pay for PFI. The National Beds Inquiry published last year stated that no more NHS beds could safely be closed. The country is now facing a major crisis in capacity, which is to be offset by greater private sector involvement. Although the government has pledged to increase the number of beds for NHS use it is not yet clear whether these beds will be in the NHS, in the private sector or in nursing homes. Nursing home beds are not the same as acute hospital beds

Raiding the budgets for clinical care

But even with all these subsidies and service reductions the costs of the PFI payments have meant that funding has had to be withdrawn from the clinical budgets of the new PFI hospital itself. PFI imposes efficiency savings on clinical staff costs. In some PFI hospitals projected staff budgets will be 25 per cent less than at the OBC and there will be fewer than 25 per cent fewer staff a greater proportion of whom will be untrained and unskilled. But there is also a knock on effect for other NHS services. Government advisors Newchurch & Co estimated that every £200m spent might require productivity improvements leading to perhaps 1,000 job losses, which might be significantly greater than 25 per cent of the workforce. This would probably only be achieved by reducing the number of doctors and nurses, although often these job losses will not be realised within the hospital undertaking the development but in the local health care market. (72)

Case study: Royal Edinburgh Infirmary

The Royal Edinburgh Infirmary scheme will be partly funded by sale of land and assets, partly funded by reductions in bed capacity (33 per cent) and finally through £13m of cost savings in clinical staff costs within the trust. In 2003 when the new hospital opens, the projected staff budget will be 23 per cent less than in 1996, and there will be almost 25 per cent fewer staff, a greater proportion of whom will be untrained and unskilled (73).

Table 5

Staff numbers (whole time equivalents) and cash expenditure on staff at Edinburgh Royal Infirmary in 1996 and under PFI plans

	Whole time equivalent staff			Staff costs		
Staff	Number in 1996	Number projected	% change	1996 (£m)	Projected (£m)	% change
Medical	544	499	-8.2	28.0	25.0	-17.0
Nursing	2144	1844	-14.0	40.0	29.0	-27.5
Clinical support	899	886	-1.4	16.5	15.0	9.0
Administrative & clerical	802	556	-30.6	12.0	8.0	-33.0
Ancillary*	502	312	-38.0	Not stated	Not stated	Not stated
Total**	**4891**	**4000**	**-18.2**	**96.5**	**77.0**	**19.0**

* Some ancillary staff will transfer to PFI contractor

** Does not include ancillary staff

Source: Pollock, A, et al, (1999) Planning the new NHS

Case study: Worcester Royal Infirmary

Under the PFI the costs of the new hospital in Worcester escalated by 188 per cent during PFI negotiations, from £49m to £108m, exacerbating the grave financial crisis. Planned efficiency savings based on bed reductions of 28 per cent were not enough and the health authority decided to substitute hospital closure for bed closure. The guillotine fell on Kidderminster, and its hospital inpatient acute services including 219 beds were closed in order to release £7.2m of income to pay for the new PFI hospital. The use of PFI has seen beds reduced by 33 per cent from the outline business case stage leaving Worcester residents with inpatient acute capacity one third of the English average. The extra costs of PFI also require reductions in staff numbers: the new hospital plans show it will have 32 per cent fewer ancillary workers and 17 per cent fewer nursing staff. Acute admissions from the surrounding area to the new hospital will have to fall by up to 37 per cent to keep patient numbers within the capacity of the hospital.

PFI and user charges

Will private finance mean user charges and private insurance? In many countries private finance means user charges and private health insurance. Indeed the use of private finance is usually an accepted way of increasing user charges. The government claims that PFI will not lead to user charges and that services will continue to be publicly funded free at the point of delivery.

The IPPR also insists that it is committed to universal services funded from central taxation (74). However, in its consideration of long term care it overlooks the government s own record in the area of long term care and personal care. The Labour government rejected the core recommendation of its own Royal Commission on Long Term Care (chaired by Professor Sir Stewart Sutherland) that personal care be free at the point of delivery (75). It has retained the principle of charging for personal care until the individual is too poor to pay. All personal care is an extension of health care — the services are considered vital to promote health and well-being and rehabilitation. But personal care is also difficult to define — when does NHS care end and personal care begin?

We have seen how the escalating costs of PFI have led to real reductions in services across the NHS and created major problems in paying for care. Meanwhile, Labour s NHS Plan (76) and the Health and Social Care Act 2001 (77) make ample provision for redefining NHS care and introducing charging and greater privatisation of NHS services. The two key innovations — Care Trusts (a new kind of NHS body) and intermediate care (a new setting for health and social care) — combine in a potent recipe for massively increased user charges.

Care Trusts will bring health care bodies and social services under a single umbrella. They will be purchasers and providers all rolled into one. Health care will continue to be free at the point of use. But social care will be charged for. The government anticipates that Care Trusts will control about 75 per cent of the NHS budget by 2004.

Intermediate care refers to care provided in order to ease the transition from hospital to home. The government wants to create an extra 5,000 intermediate care beds by the middle of 2004. Some will be in community hospitals, others in special wards in acute hospitals and some in purpose-built new facilities or redesigned private nursing homes. The plan also aims to introduce 1,700 extra non-residential care places.

The government has recently introduced guidance time-limiting NHS care (78). Based on current practice an intermediate care episode should typically last no more than six weeks. Many episodes will be much shorter than this, for example, 1-2 weeks following acute treatment for pneumonia or 2-3 weeks following treatment for hip fracture... Thereafter, NHS care — meaning nursing and medical care — will be provided free of charge; but means-tests and user charges will apply to housing and living costs and to the costs of personal care . It has also introduced into the Act mechanisms for topping up services for those prepared to pay for extras out of pocket. Care will in this case be provided on the ability to pay and not need.

It requires no great acumen to see that Care Trusts, laden with PFI debts, will have a strong interest in redefining NHS care and defining personal care as broadly as possible and encouraging patients to top up care. All these steps will help them maximise revenue from user charges. Issues are bound to arise over the status of many ordinary tasks of daily living (mostly centring on washing, feeding and toileting). When is giving a patient a bath, for example, medical care and when is it personal care? It will be up to Care Trusts to say.

Already companies such as Norwich Union finance, own, and operate GP premises while others such as BUPA and PPP hospitals provide NHS care to NHS patients. These companies currently promote and sell private health insurance as well as privately funded health care. There are *no* provisions in the Act prohibiting the sale and promotion of private health insurance or privately funded health care to NHS patients from NHS purchasers and providers, such as Care Trusts. Public Private Partnerships and Care Trusts blur the boundaries for funding and responsibility for provision making backdoor privatisation much easier. (79)

These changes will greatly favour the development of an expanded market in private medical insurance. It may be that insurers will offer policies that take effect at the point where the care provided by care trusts ceases to be free. Holders of such policies could, for example, be entitled to longer stays in hospital with the insurer meeting the cost no longer covered by the state.

6
Conclusion

The claim that it is not who delivers the service that matters, but the quality of service outcomes, has a simple logic to it which discourages both scrutiny and public debate. There are however important issues at stake. Relying on private companies to provide state funded services introduces new stakeholders into the system with a financial claim on public revenues. It will almost certainly lead to an increase in administrative costs and will move public services further away from democratic control.

The IPPR makes its case for extending Public Private Partnerships by ignoring and downplaying the evidence of its cost and efficacy, and the context in which it operates. Any honest and objective evaluation of the evidence shows that the extension of PPPs will lead to ever increasing costs for the public sector and major public sector deficits, with consequent cuts in access to and the quality of services provided. Ultimately it raises the spectre of rationing and user charges.

The Health and Social Care Act 2001 promotes the Concordat between the NHS and the private sector and enables greater privatisation without recourse to PFI. It promises a feeding frenzy of new market entrants and opportunities not just to take a bigger share of NHS services but to gain access to patients for the sale of health insurance and health care. The result, as shown in Part 5, will be higher cost, lower quality and decreased access. This will be mirrored across public services such as education, housing, and transport.

The IPPR have ignored the very purpose of public services and their social basis. There is no case for markets or for-profit operators in the delivery of health care, education, long-term care, or many other public services. No country in the world has delivered universal public services on the back of for profit providers. The costs are too high, the risks are too great, and markets are not and cannot be oriented toward social equity goals.

Appendix: The IPPR Commission

The IPPR Commission s inquiry was carried out away from public scrutiny; its meetings were held in private and the proceedings are not available to the public. Its make-up represents a striking coalition between big business and government, Commission members having direct links into many of the key government departments.

The Commission members and its sponsors are not ideologically neutral. A growing share of the sponsors revenues and profits are built on the back of billions of pounds of public funds and government contracts. Schools and hospitals are not only high on the government s agenda, they are also high on the agenda for trade.

The sponsors have a vested interest in creating market opportunities and access to public funds in health and education. Multinational companies see social protection measures including public services as barriers to trade and obstacles to profit. Public services have been protected from the market by financial and institutional arrangements, but these barriers are being dismantled by the Treasury and will now provide the private sector with unprecedented access to public funds. These funds include the ringfenced annual thirty-year PFI payments from the government to the private sector (see Part 1). Market analysts estimate that expanding trade in public services could yield the private sector £30 billion extra revenue a year, of which £10b is central government contracts, £5b education and £5b local authority contracts. The sponsors have been quick to recognise the possibilities and have positioned themselves to expand trade in education and health, not just in the UK but internationally.

Education is a key growth area for Commission sponsor Serco. Ninety per cent of all its business is government contracts and half of all its business is based in the UK. According to Investec Henderson Crosthwaite the whole world is looking at what Serco is doing in terms of using private funding to build and update government and quasi-government assets .

Health is a key growth area for Nomura, Norwich Union, the General Healthcare Group, and KPMG. Nomura is a Japanese-owned global investment bank, ranked in the top 10 of the world s major international finance houses. Norwich Union and CGU (Commercial and General Union) is now the largest insurance group in the UK and one of the top five life companies in Europe. Norwich Union Healthcare, the health care arm of Norwich Union, is an aggressive promoter of income

protection and private medical insurance (PMI) products. The General Healthcare Group is the largest private hospital provider in the UK. It is positioning itself for a greater share of NHS work following the signing of the concordat between Alan Milburn and the Independent Health Association last year. KPMG has negotiated more than £7.5b public sector deals using PFI and PPP. KPMG claims it is the dominant adviser to the NHS Executive . The company s influence in the NHS and at the Treasury is extensive.

The sponsors

Serco is a rapidly expanding company specialising in facilities management and outsourcing services particularly for the public sector. It has a £967m turnover and £38m profit. 90 per cent of all its business is government contracts and half of all its business is based in the UK.

International government contracts include: management of a US naval base in the Pacific; the bus service in Adelaide; training flight controllers and instructors for the Russian Federation; an Italian computer and communications support service; air traffic control with the US Federal Aviation Administration; contracts with CERN nuclear research institute in Geneva; the Forsmark nuclear power station in Sweden.

UK government and local authority contracts include: the Atomic Weapons Establishment; the newly-built Ministry of Defence (MoD) Joint Services Command and Staff College; the maintenance contract for Railtrack; Manchester s tram system; the Docklands Light Railway; private prisons; and NHS hospitals. The Serco-led Novartis consortium failed to win the National Air Traffic Control project in 2001. 1,200 air traffic maintenance staff would have been laid off, and subcontractors employed — as happened with Railtrack.

Its prison work includes joint ventures with the notorious US Wakenhut Corporation at Lowdham Grange, Kilmarnock, Medomsley, and Ashfield. Several states in the US have terminated contracts with the company and Australia has threatened to do likewise. Serco itself has a reputation as an aggressive cost cutting operation (Daily Telegraph) provoking numerous union disputes from Adelaide to Labrador and Aldermaston. Employees are routinely refused any form of collective bargaining while numbers are often cut by as much as 40 per cent.

Serco has a stake in Partnerships UK, the quasi-governmental project set up to

stimulate PFI. (Notably its forerunner, the Private Finance Panel, a Treasury body with the same remit, was led by David Steeds whose previous job was Corporate Development Director at Serco). Currently it has Mike Craven of Westminster lobbying firm Lexington (and who has worked as an advisor to John Prescott) to promote its interests. Investec Henderson Crosthwaite have said the whole world is looking at what Serco is doing in terms of using private funding to build and update government and quasi-government assets. The Labour government is offering larger contracts than anyone else in the world and other markets such as the US, continental Europe and Japan are set to do the same .

Nomura is a Japanese-owned global investment bank, ranked in the top 10 of the world s major international finance houses by the Wall Street Journal in September 1999. It plays a significant role in all key markets of the world, offering securities brokerage, investment banking, trading, and venture capital.

Highlighted deals include: £53m Initial Public Offering for Synergon, a Hungarian technology company; handling one of the biggest and most visible health care mergers between Shield Diagnostics and Axis Biochemicals with the enlarged group valued at £165m; offering the Unique Pub Co, the UK s largest independent landlord, a new £130m funding facility to be used for further acquisitions; First Quench off licences for £225m; acquisition of 1,240 Partnership pubs for £370m; of Thorn consumer goods rental company for £980m; the £700m purchase of 1,500 William Hill betting shops; the £1.7bn purchase of 57,000 residential homes from the MoD; the purchase of the rolling stock company Angel Trains, including 3,600 railway engines and carriages from the UK government for £696m.

Nomura s European division, Nomura International, has according to the company s website one of the largest teams dedicated to the health care sector in Europe, including 7 equity research analysts, 15 investment bankers and 19 specialist salesmen in the US and UK . Corporate health care investors include Medisys, Axis-Shield, Intercare, and Anitsoma, and Nomura advises on the full range of mergers, acquisitions, divestments and investment within the health care sector, with a particular focus on cross-border transactions . The Principal Finance Group, the finance arm of Nomura International, was recently frustrated in its attempt to buy the Millennium Dome.

Six months before the IPPR Commission was announced, Nomura set up a £1bn infrastructure fund with Serco to bid for large-scale, complex PFI/PPP projects. Nomura would provide the funding while Serco would run them. As Corporate

Money reported, although both partners are heavily involved in the privatisation of state assets, this is the first time that an experienced project manager will be linked with so much capital. Serco s CEO Richard White said the fund would enable the partners to pursue new and exciting opportunities without being limited by financial resources or management expertise (80). The infrastructure fund was meant to have been used for the London Underground and National Air Traffic Control. The infrastructure fund did bid for the 750 properties occupied by the Inland Revenue and Customs and Excise. It was unsuccessful, the contract going to the George Soros/Morgan Stanley consortium.

When Nomura failed in its bid for the DSS estate due to the absence of an FM capability it bought the FM business of Turner & Townsend in 1998 and created Servus. Servus has about 100 staff, mainly consultants, managers, and engineers while its sub-contractors retain the existing maintenance staff of those companies whose buildings it acquires. Contracts include Department of Trade and Industry (DTI) headquarters office portfolio; and management of London Electricity s investment portfolio of more than 90 properties.

Norwich Union merged with CGU (Commercial and General Union) in May 2000 to form a world-wide business valued at £24bn, creating the largest insurance group in the UK and one of the top five life companies in Europe. Focusing on long-term savings, fund management and general insurance, it has 70,000 employees, more than 15 million customers and worldwide premium income and investment sales from ongoing business of £27bn. Group results from 2000 incorporate operating profits of £1.4bn, with assets under management of £220bn worldwide and £128bn in the UK alone. Prior to the merger Norwich Union itself, in 1999, revealed new business growth of 50 per cent to an annual premium equivalent of £630m, including a 46 per cent growth in the UK. Worldwide operating profit for the year was £717m.

In 1990 Norwich Union Healthcare was formed as the health care arm of Norwich Union and now provides a range of income protection and PMI products to around 600,000 people. Its now one of the largest PMI providers in the country.

In 1998 Norwich Union and property company, the Mill Group, set up the Norwich Union Public Private Partnership (NUPPP) which was described as the first major institutional fund to provide total serviced facilities under PFI, combining long-term committed fund, property investment and services delivery. Initially the fund was capitalised at £100m and to be managed on a day-to-day basis by the Mill Group.

It s since been doubled to £200m. The fund is specifically targeted at investment opportunities of between £15m and £35m in the education, general accommodation and non-acute health sectors.

These include: Dudley Priority NHS Trust — a groundbreaking £3.5m health and social care centre providing dental, family planning, home care services, library and a base for the local mental health team; Bradford Community NHS Trust — a £4m primary care facility; Central Nottinghamshire Healthcare NHS Trust — a £1.42m purpose-built mental health and learning disability resource centre in Newark; Canterbury College — a £35m construction and relocation of the campus; Newham Council — a major schools building and maintenance contract worth in excess of £44m to provide three schools. It was notable as one of the fastest multi-schools signings under PFI, with a 25-year contract for design, build and operate including services such as maintenance, cleaning and catering. Brighton and Hove Council — design and build of a £20m central library.

The General Healthcare Group (GHG) has three areas of clinical service: acute surgical and medical hospitals; acute psychiatric; and preventive care
The Group provides its acute services under the BMI Healthcare brand and is the largest independent provider in the UK. It has over 40 hospitals with a total of 2,300 beds, 115 operating theatres, and 39 intensive care beds. Involvement with the public sector includes management of NHS private facilities, the leasing of facilities within NHS Trusts, and working with Trusts and health authorities on waiting times. A number of smaller BMI hospitals are located on NHS sites. As GHG s website says, BMI hospitals have rapidly established their position as market leaders in such public private partnership ventures, providing a complementary private patient service linked to an NHS hospital.

GHG s psychiatric division, Partnerships in Care, is the leading provider of specialist psychiatric rehabilitation and non-acute care in the UK. Patients are mainly public sector funded. In significant mental illness and personality disorders, PiC has a 49 per cent share of the independent market and a 14 per cent share of the total market including NHS facilities.

GHG was until August 2000 controlled by various investment funds managed by Cinven, a company described as the leading provider of private equity for larger European buyouts . Cinven bought GHG as part of a £1.1bn acquisition of Compagnie Generale des Eaux, at the time the largest European management buyout of the decade. Prior to this buyout Cinven owned Amicus, the UK s fourth-

largest hospital provider in the UK. It duly merged GHG and Amicus in December 1997 to form the largest private hospital provider in the UK. Its strategy gave GHG 20.7 per cent of independent beds available and 23.2 of their revenue, pushing BUPA out of first place.

UNISON reports that GHG has traditionally been anti-union with poor working conditions for nursing and clerical staff. It has attracted a number of allegations concerning poor standards of nursing care, dubious psychiatric practice and overcharging insurance companies.

KPMG is described variously as a global professional advisory firm, an accounting firm and a consultancy operation. It reported record revenues of £13.5bn for the year ending September 2000. Its consultancy arm made profits of £31m on revenues of £2.4bn with 34 per cent sales growth per year over the past 4 years. It advised on more deals (523) worldwide in 1999 than any other firm, and also topped the European rankings.

KPMG is being sued by US government departments for allegedly submitting bogus expense claims to defraud Medicare in Florida with the large health care multinational Columbia/HCA, and for allegedly setting up illegal contingency funds for the HMO SunStar Health Plan. Columbia/HCA currently owns a large proportion of private beds in London. It has also had problems with the new Securities & Exchange Commission crackdown on audit conflict of interest.

The company s influence in the health sector has longstanding roots. Baroness Noakes (formerly Sheila Masters) is a partner at KPMG UK. From 1989-91 as NHS Executive director of finance she was instrumental in introducing the internal market. She is currently overseeing projects on NHS outpatient performance, disposal of the NHS estate, IT development, and human resource management in the NHS. All these are via the Treasury s Public Sector Productivity Panel. The report, Sold on Health, which she produced aims to root out surplus estate, accelerate sales and cut red tape .

KPMG s influence in the UK public sector continues apace with the company securing footholds via several government departments. Its website indicates long-term partnerships with the MoD, the Department for Education and Skills, and the Cabinet Office. It also claims a traditional market leadership in providing advice to the public health sector on strategic and large-scale operational issues, and is the dominant adviser to the NHS Executive .

KPMG has advised on over 50 PFI projects in the health sector with 29 so far coming to financial close, including Greenwich, King s Healthcare NHS Trust, Bishop Auckland, Herefords Hospitals NHS Trust, and Dartford & Gravesham. Most if not all involve NHS hospital and bed closures. The company also runs a large functional benchmarking service for over 70 NHS Trusts providing a range of performance improvement and cost reduction services . It has advised BUPA on setting up new facilities and other hospital groups on the feasibility of establishing a network of private GP s. It also helps pharmaceutical and medical product suppliers in determining strategies and growth possibilities.

Commission membership

The Commission represents a striking coalition between big business and government. Commission members have direct links into many of the key government departments.

Martin Taylor, the Commission Chair, is Chairman of WHSmith and International Advisor at Goldman Sachs. He headed the government s task force investigating the reform of the tax and benefits system. **Kate Barker** is Chief Economic Advisor to the CBI, and was a member of the Chancellor s Panel of Economic Advisors. **David Denison** of ICL develops the firm s relationships with local government and represents the CBI on the Department of Environment, Transport and the Regions (DETR) Best Value Steering Group. **Chris Nicholson** is a Partner at KPMG advising on privatisation and PFI finances, and was previously an Economic Advisor at the DTI.

Shriti Vadera, a member of the Principles Working Group, is the Treasury s top negotiator on the partial privatisation of the London Underground and a member of the NHS Capital and Capacity Taskforce which investigates the scope for private sector involvement in clinical support services. She formerly worked on the privatisation team at investment bank Warburg Dillon Read. The Principles Working Group also included the BBC s Director of Finance, Property and Business Affairs **John Smith**, responsible for both introducing private sector competition for license collection and enforcement and for moving the BBC to a full market and cash economy. He also, in 1996, helped negotiate the five-year licence settlement and the financial systems joint venture with IT giants EDS and Coopers & Lybrand.

Others on the Commission have a record of actively promoting the case for

partnerships with the private sector of various kinds.

Professor **Gerry Stoker** of the University of Manchester is chair of the New Local Government Network, a pressure group for local government modernisation which receives financial backing from consultancy firms and service contractors including KPMG, Serco, the CBI, ICL, BT, and Capita. **Claire Perry**, who as Chief Executive at Bromley Health Authority carried through a controversial PFI deal for Bromley Hospital, is chair of the New Health Network which operates on a similar model with respect to the health service, with backers including Superdrug, Chai Patel s Westminster Healthcare, and, again, KPMG.

Bill Callaghan (Health and Safety Commission) and **Sarah Ebanja** (Government Office for London) are both members of the 20:20 Forum, a broad-based educational organisation aimed at stimulating debate on partnership arrangements, wealth creation, and new forms of governance.

Peter Fanning of 4Ps and the DETR s **Richard Footitt** (who both sat on the Local Partnerships Working Group) co-authored the document on standard documentation for PFI contracts. 4Ps is a consultancy set up to help local authorities develop and deliver PFI and PPP schemes. Mainly funded from government grant, 4Ps offers advisory services and bespoke project support with its board including Local Government Association appointed councillors and private sector representatives. Working closely with the then Treasury Taskforce and the Improvement and Development Agency (IDeA) 4Ps role is that of disseminating of know-how, guidance and best practice, facilitating access to PFI credits and promoting PFI events, conferences, and publications. Again it has close links with both the Department for Transport, Local Government (DLTR) and the Regions and the Treasury, through membership of the DTLR s advisory panel on PPS in local government, and producing PFI guidance for the Treasury Taskforce.

The Working Groups have two columnists from the Financial Times, and the editor of Management Today, Britain s leading monthly business magazine .

The one working trade unionist on the IPPR Commission, **Jack Dromey** of the TGWU, appears to have withdrawn before the publication of the final Report.

Commission members	
Martin Taylor (Chair)	WHSmith, Goldman Sachs
Kate Barker	CBI
Bill Callaghan	Health & Safety Commission
David Denison	ICL
Jack Dromey*	TGWU
Sarah Ebanja	Government Office for London
Ruth Kelly	MP for Bolton West
Julian LeGrand	LSE
Chris Nicholson	KPMG
Claire Perry	UKCC
Amanda Root	Local Government Centre
Victor Smart	Planning Magazine
Gerry Stoker	Manchester University
Matthew Taylor	IPPR
Gavin Kelly, Peter Robinson, Paul Thompson, Rachael Lissauer, Ella Joseph (IPPR Secretariat)	

* Not acknowledged in Commission s final Report

Working groups composed of the above members plus:

Working group 1: principles	
Shriti Vadera	HM Treasury
Andrew Gamble	University of Sheffield
John Plender	Financial Times
John Smith	BBC
Working group 2: the public finances, value-for-money and contract design	
John Hawksworth	Price Waterhouse Cooper
Jeremy Colman	National Audit Office
Richard Nicholls	
Working group 3: PPPs in the core public services: health, education and criminal justice	
Dan Corry	DTI
Tania Burchardt	LSE
John Tizard	Capita
Terry Powley	North Southwark Education Action Zone
Working group 4: local partnerships	
Alan Pike	Financial Times
Peter Fanning	4Ps
Andrew Westall	IPPR
Richard Footitt	DETR
Steve Jacobs	Stratford Development Partnership

Notes

1 IPPR, (2001) Building Better Partnerships: The final Report of the Commission on Public Private Partnerships, London, IPPR.

2 Branigan, T, (2001) Ministers given a warning on emergency plans to rescue public services , The Guardian, 26 June 2001.

3 See for example pp. 18-19, and the critical accounts of partnerships schemes proposed for London Underground and the National Air Traffic Control Systems (NATS) in Chapter 5.

4 There is scope for policy-makers to encourage greater diversity in provision across the health, education and local government sectors ; The conclusion we reach is that policy-makers should be willing to promote a degree of diversity in most areas of provision . IPPR, p. 7; p. 141.

5 Problems afflicting PFIs and PPPs reflect the lack of a clear narrative about partnerships ; a desire to make the case for partnership is required for the future. IPPR, p. 19, p. 256.

6 IPPR, p. 33.

7 Our view is clear on this. We believe that the arguments used to maintain these no-go areas are often flawed . IPPR, p. 43.

8 IPPR, pp. 40-41.

9 The spurious argument [for PFI and PPP] is that using private finance to pay for capital investment allows government to undertake more projects than would otherwise be the case. All PFI projects are publicly funded and incur future liabilities for the exchequer. IPPR, p. 4. See also HSHPRU, (2001) Public Services, Private Finance: Accountability, affordability and the two-tier workforce, a report for UNISON by the Health Services and Health Policy Research Unit, London, UNISON, Section 1.

10 IPPR, pp. 81-81.

11 IPPR, p. 59.

12 IPPR, pp. 59-62.

13 See HPHSRU, (2001), Section 1, p. 11. Public sector bodies are continuing to structure deals to maximise the chance of securing off balance sheet treatment, and they are doing so because they have been advised by their departments that this is what is required if they are to receive revenue support. This reflects the position of government departments which would see their own capital budgets

reduced if deals were recognised on the balance sheet.

14 Department for Education and Employment, (1998) Public Private Partnerships: A Guide for School Governors, London, DfEE. www.dfee.gov.uk/ppp/intro.htm

15 IPPR, p. 44.

16 The potentially serious argument [for PFI and PPP] is that in the right circumstances PPPs can offer significant value-for-money gains and generate improvements in service quality ; The move towards a more diverse public service sector opens up possibilities for drawing on the skills of leading edge private and voluntary organisations. IPPR, p. 4; p. 47.

17 See Section 5 below.

18 See HPHSRU, (2001), p. 24: In all the business cases we have examined, the value-for-money of the PFI option is dependent on the valuation of risk transferred to the private sector.

19 National Audit Office, (2000) The Financial Analysis for the London Underground Public Private Partnerships, London, TSO.

20 IPPR, p. 87.

21 See HPHSRU, (2001), p. 24: The very low interest rates at which PFI contractors are able to borrow can only reflect the judgement of lenders that there is very little risk that they will not receive anticipated interest and the repayment of the debt in full.

22 HPHSRU, (2001), Appendix 1.

23 The use of reductions in staff budgets to fill PFI affordability gaps has been well documented in the NHS. See Gaffney, D, Pollock, A, Price, D, and Shaoul, J, (1999) NHS capital expenditure and the private finance initiative — expansion or contraction? , BMJ, 319, pp. 48-51; Gaffney, D, and Pollock, A, (1999) Downsizing For The 21st Century: A report to UNISON on the North Durham Acute Hospitals PFI Scheme, London, UNISON; and Price, D, Gaffney, D, and Pollock, A, (1999) The only game in town? A report on the Cumberland Infirmary Carlisle PFI by UNISON Northern Region, London, UNISON.

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38 IPPR, p. 63.

39 IPPR, p. 198.

40 Ibid.

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42 Ibid.

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45 Knapp et al, (2001).

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47 Ibid.

48 IPPR, p. 150.

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