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Managing risk and regulation within new local ‘health economies’: the case of NHS LIFT (Local Improvement Finance Trust)

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Abbreviated title: Risk, regulation, and NHS LIFT

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This paper analyses NHS Local Improvement Finance Trust (LIFT), a relatively new policy that shifts UK primary care premises into corporate ownership. LIFT is a more radical version of the Private Finance Initiative (PFI), and may indicate the future direction of neoliberal welfare services. Like PFI, LIFT foregrounds issues of risk and regulation, enabling their reconceptualisation. This echoes certain themes present in the sociology of risk, including the idea that the welfare state has created and amplified, rather than managed, risk. Under LIFT, risks are constructed as (a) primarily economic and (b) primarily from the point of view of the large commercial organisations involved. Evidence presented here depicts banks as risk averse, challenging assumptions that private firms display risk-taking behaviour.

The prioritisation of economic risks is shown to amplify social risks, and to produce threats to social regulation. These threats are amplified by unequal power relationships within these new ‘local health economies’. It is argued that LIFT is undermining the NHS’s social embeddedness in local areas, partly by threatening the position of general practitioners and other small business or community organisations. Ultimately the model is likely to generate new social and economic risks currently obscured by official discourse around LIFT.

Introduction

Policy change both enables and is enabled by new concepts of risk and regulation. In the UK, discourses of risk have been a key means of justifying new ways of involving the private sector in providing public services, such as PFI (the Private Finance Initiative, in which facilities are designed, built, financed, owned, and maintained by private firms,

and leased back to the public sector). Supporters argue that such policies transfer risk to the party best placed to manage it, and quantifications and comparisons of risk figure centrally within PFI Value for Money assessments (Stapleton et al 2004). This paper will focus on NHS Local Improvement Finance Trust (LIFT), a new organisational form developed from PFI, which is an example of the complex models of privatisation and part-privatisation currently transforming public services in the UK.

An official narrative sees public sector failure as creating pressure for these new procurement methods. In a report supporting the LIFT model, consultancy company Capita states that “[o]ne of the main reasons why pfi was adopted by government in general and the health sector in particular was in the forefront of the policy was to transfer the major risks [sic], firstly of delay and secondly, cost overruns which had featured prominently in number of very high profile projects which went badly awry.” (Capita 2007:14)

But this oft-rehearsed story does not explain why the tale is being told in the language of risk, or why risk transfer is seen as the appropriate solution to the ‘problem’. Risk is fashionable: but what does it do here? What kinds of risks are being constructed and prioritised – and who is bearing them? Finally, how is social regulation (by which I mean the ways in which contemporary institutions are embedded in, and supported by, civil societies) working when confronted with new structures and new risks?

LIFT: a dramatic shift in primary care provision

Before LIFT (Local Improvement Finance Trust), UK primary care (care outside hospitals) was located between state and market. When the National Health Service was created in 1948, GPs (general practitioners or family doctors) did not become NHS employees, whereas hospital doctors did. GPs remained “independent contractors” running local surgeries, selling their services to the state. The majority of surgeries continued to be owned by GPs, and over the next fifty years the resulting patchwork of regulated small producers proved highly stable. As GPs consolidated their independent professional power base within the NHS, investment in primary care premises and facilities remained limited (Pollock 2004)

If the NHS stayed on the margins of direct primary care provision for fifty years, corporate capital was even less involved. A minority of GPs rented premises from specialist private landlords but the market was too small and fragmented to interest large firms (whose corporate structures might also not be best placed to deal with GPs). As post-1997 Labour administrations promoted PFI in the NHS, initially this focused upon acute care (hospitals), not primary health care buildings. LIFT overcomes the problem of low corporate interest in small projects by bundling buildings together within a long-term partnership approach, which ties local NHS organisations to a majority corporate owned LIFT company (LIFTCo) (Aldred 2007). (By contrast, PFI creates a company to manage one particular project.) LIFT is now under way in around half of English NHS primary care trusts. In these areas NHS organisations have signed an “exclusivity clause” stating that over during a 20-year “Strategic Partnering Agreement” a local LIFTCo has Quantifications and comparisons of risk sole rights to develop any new primary care premises (such as GP surgeries and health centres) in its area. It will then lease space in the buildings to service providers, also providing some support services.

LIFT mandates a “public sector shareholding” which means that local NHS Trusts must purchase a 20% stake in “their” LIFTCo. Another 20% belongs to the national agency Partnerships UK (until recently itself also a PPP) and the remaining 60% to the private investors. These investors generally comprise a financial institution, a support services company, and a construction company. The obligation in LIFT areas to provide new primary care premises through the LIFTCo represents a substantial change in the provision of primary care accommodation, albeit one that will take place gradually. For example, primary care trust maintenance departments are likely to transfer over time to the support services company involved, but this will not happen with the signing of the initial contract. Similarly clinical, other support services, and even local authority-run services might transfer in the future (Aldred 2007).

The data discussed here are derived from an embedded case study of NHS LIFT, using interviewing, non-participant observation, and analysis of official documents. This research included analysis of the policy at a national level, an in-depth study of one particular LIFT area (and the numerous organisations constituting it), and complementary studies of three LIFT comparator areas. The narrative draws upon research into the broader policy framework surrounding LIFT and PFI.

Talking about risk: policy and public sector projects

The case of LIFT demonstrates how certain themes in the various sociologies of risk chime with the dominant contemporary PPP¹ risk narrative. Beck (1992) has characterised contemporary societies as “risk societies”. Here risk becomes part of a cautionary modernisation narrative: modern societies create risks that they are ill-equipped to manage, and management strategies themselves come to amplify risk. Pro-PPP discourse, which highlights risk transfer, has some similarities to Beck’s approach and to Giddens’ (1991) related analysis of primary and secondary modernity.

The Giddensian approach would suggest that under primary modernity the public sector was trusted with large projects to contain and manage social problems. This would be counterposed to secondary modernity, in which there is a growing awareness of the problems caused by these projects themselves: for example, large capital projects may often over-run or go over budget. PFI could be seen as developing from the realisation that public sector capital projects exacerbate or even cause, rather than manage, risk.

Indeed “social entrepreneurs” within the “LIFT community” promote PPP as offering to bypass the state in favour of a dynamic collaboration between private sector organisations, service users and community groups (Aldred 2007b). These new networks would join together non-state and civil society actors within new hybrid organisational forms, responding to disillusionment with state provision. Risk stories that explain and justify PPP focus upon the failure of only one type of large primary modern institution: the state. By contrast, large corporations are cast as privileged carriers of late modern virtues such as flexibility and networking (Aldred 2007c).

This discourse echoes analyses of risk as governmentality stressing a shift from centralised state government to more diffuse, networked governance. Documents supporting PPP speak of the benefits of “networking” over the “silo” mentality allegedly represented by traditional public sector service demarcations (Aldred 2007). Such soft governance is attractive to managers for a number of reasons, not least because service

¹ Here I am using PPP to refer to PFI, LIFT, and similar initiatives such as Building Schools for the Future.

users and/or staff may become “responsibilised” and internalise managerial goals (Rose 1996). But under closer examination LIFT and PFI sit uncomfortably within this scene: instead, I show below that a focus on the narrowly conceived economic (primarily constructed from the viewpoint of private sector partners) risks costly failures to deal with social risks and provide effective social regulation.

The analysis here calls into question associations commonly made between the private sector and pro-risk attitudes both in PPP discourse and in the sociology of risk. Douglas and Wildavsky (1982) associate individualistic attitudes and acceptance of risk-taking with industry and enterprise, and hierarchical attitudes to risk with bureaucratic state organisations such as government regulators. Official discourse promoting privatisation echoes this view. The National Audit Office argues (NAO 2006:3) that “a culture of risk aversion and a lack of commercially skilled individuals” obstruct the commercialisation of government activities.

Among the public-private elite, the superiority of the private sector’s approach to risk is taken for granted. NAO Auditor General Sir John Bourn told a conference of PFI industry managers in 2003 that state failure to understand, recognise, and deal with risk has meant that the public sector has been “in a somnambulistic way, as I put it, walking off the end of a cliff.” Trying to avoid risks not only prevents innovation, but is ultimately self-defeating, creating additional risks. Similarly, at a national LIFT symposium in London in 2006 attended by senior NHS and private sector managers, “civil servants” (central government bureaucrats) were criticised as stalling service improvement through a refusal to accept any risks (Aldred 2007). Such discourse occludes the politics of risk in favour of a one-dimensional spectrum of risk preferences, frequently mapped onto a private/public distinction. However, my research shows a more complex picture, with the construction of “economic” risks generating unforeseen “social” risks.

Risky business: commodification and entrepreneurialism

The calculation of risk does not necessarily imply its commodification: calculating allows risk to be spread over a number of projects, reducing uncertainty. A public sector organisation might – for example – have fifty different small projects each with an

estimated 2% risk of failure.² The authority would expect that one of its projects is likely to fail, and can plan accordingly. Risk is then normalised as part of organisational planning, and from this perspective the state seems well placed to manage it. Unlike most commercial organisations the state is involved in many different areas, so that risk can be pooled over projects with different types and levels of risk.

However, with the growth of policies such as LIFT, the risks attached to public services are increasingly subject to commercial as well as managerial logics. Public-private partnerships have created new markets in risk, as did the original pioneers of risk commodification: the insurance industry. Risk conceived as a tradable commodity is a material category, acting in the world to transform uncertainties into profit (Jureidini and White 2000). In PFI and LIFT, secondary markets are developing with players such as the Secondary Market Infrastructure Fund, which claims to be the largest asset manager in the UK PFI/PPP market place.

For PFI and LIFT to be possible, NHS organisations needed to be constituted as NHS Trusts – financially bounded accounting entities³. The concept of an accounting entity “draws a line around a set of economic resources and allows reports to be prepared which reflect the entity’s financial position and the economic events related to it” (Hodges and Mellet 1999: 278). This enables an event to appear in multiple ways and places; a sale appears on one entity’s balance sheet as a disposal of assets and on another’s as an acquisition of assets. Under PFI, different aspects of an asset (ownership, finance, risk, control, and benefit of output) appear in different places. Ownership may even disappear between the balance sheets in question. Not only is an asset commodified, but it is deconstructed and its component parts commodified.

PFI and LIFT are interesting because they do not fit the classic picture of risk transfer analysed by post-Foucauldian authors such as Rose (e.g. 1996). Here risks are apparently privatised, but not in the sense of individualisation (passing them down and out of the organisation onto the individual). Accordingly, in LIFT attempts at “responsibilisation” (moral exhortation to behave correctly) are targeted at local public

² Obviously simplifying here, as risk is measured by multiplying impact by probability.

³ All NHS organisations were constituted as Trusts by the Conservatives between 1991-1995, and this was not repealed by Labour.

sector managers, who are urged to act more entrepreneurially, and associate themselves with the financial fortunes of “their” LIFT Company (Aldred 2007).

By contrast, where risks are individualised the targets are ordinary citizens, who are warned that they should stop smoking, eat healthily, save for the future, attend training courses, etc. Under PFI and LIFT, the future recipients of privatised risks – large firms – are assumed to be good risk-managing subjects who respond appropriately to incentives. While private *individuals* are suspect and need to be educated (even threatening to deny medical treatment may leave some smokers recalcitrant!), private *companies* appear as rational actors. Failure must be the responsibility of the state’s failure to transfer risk effectively; the alleged failures of public sector contracting often actually refer to the failure by private companies to perform on time and to budget, recast as regulatory failures of the state.

The LIFT structure is designed to pass on risk. It creates a web of holding companies (FundCos) suggesting that profits will be taken out through these FundCos rather than through the parent LIFT Company itself⁴. FundCos are 90% debt financed; after paying off their contractors (often consortium members or their sister companies), and debt interest to financial backers, it is not clear how what (if anything) would be passed back to the parent LIFT company (and its minority public sector shareholders). The use of holding companies to distribute profits and risks is not surprising: risk specialists advise PFI consortia “to transfer risks out of the [Special Purpose Vehicle – i.e. in this case, the FundCos] down to subcontractors or suppliers, leaving very little risk to be borne by the SPV itself” (Walker 2005).

However, this structure does suggest that the corporations involved in LIFT may be themselves be more interested in avoiding risk than in managing it themselves. Indeed, the majority of my interviewees agreed that private sector companies, in particular banks, were highly risk *averse*, which in itself implies that the public sector may not get good value for money when attempting to transfer risk to the private sector. Public sector managers in case study and comparator areas argued that the private sector had not been “as clever as we’d have liked” (in one manager’s words) and had

failed to take the initiative in planning innovative projects (Aldred 2007). They complained that the private sector wanted “quick wins” and was not adept at providing added value and the promised synergies. One example of this on a national level is GP leasing.

Initially, it was planned that LIFT companies would take on the risk of not only renting “retail” spaces, but also of renting space to general practitioners. The DH website states “[LIFTCo] will rent accommodation to GPs on a lease basis... NHS LIFTs will offer GPs flexible lease arrangements.” A paper produced by PriceWaterhouseCoopers laying out the proposed LIFT model argued that the NHS would benefit from this in two ways: it would pass on demand risk and become better able to manage relationships with GPs. “The key objective of the NHS to develop flexible relationships with the local GPs as part of primary care PPP’s [sic] could be facilitated by passing an element of demand risk through to the private sector” (PWC 2001:18).

But instead, PCTs are taking twenty-five year “headleases” on LIFT properties and subletting to GPs. The NHS, not the private sector, has been able to offer more flexible terms to GPs, but this means that the NHS bears the risk of GPs leaving or defaulting. The private sector is guaranteed long-term income from the state for most of the premises built, minus the usually relatively small proportion of space used as “retail units”. Each FundCo (individual project company) represents a liquid, ready-made investment with contracts and subcontracts in place: owners should merely need to wait for income to arrive each year. One interviewee commented that it was an ideal investment for risk averse pension funds. It is not in the private sector companies’ interest to take the risk of entering into short term or uncertain leases: it reduces the value that they will be able to realise if and when the project is sold on the secondary market.

This is confirmed by the generally positive Capita report on LIFT (2007:4) which acknowledges: “the banks are normally, extremely cautious and paranoid [sic] about any risk remaining within the LIFTCo/FundCo structure without it being set off to a third party entirely. This means they can be very pernicky and will challenge minor details.” This

⁴ This structure allows liability to be strictly limited to initial investments in each “Fundco” or project holding company; thus financial difficulty affecting one project will not affect investors’

hardly represents an imaginative or innovative approach to risk. Indeed, in case study and comparator areas public sector managers argued that the private sector’s wish for simplicity and guaranteed cashflow inhibited novel projects. A mental health trust director told me that the financial institution involved in his project had imposed insurance charges of more than double the usual rate, and these costs had been passed on to the NHS organisations involved. Another manager said “[LIFTCo] want the GP surgery that we were going to develop, with nothing really added, maybe a community room or whatever. So that in effect, the project is simple and can be run very quickly.”

Defining risks: the visible and the uncountable

Despite the visibility of risk under LIFT and PFI, definitions of risk categories are narrow. Hood and McGarvey (2002:27) cite “the general acceptance by contractual partners that there are distinct and finite categories of risk that should be considered under PFI projects. These risks are normally categorized as design; project finance; construction and operation, including maintenance; demand/variability of revenue; technology and obsolescence; regulation and legislation risks; and residual value.” According to Walker (2005) the risks are apportioned as follows (at least in theory):

Risks usually retained by government	Risks usually transferred to private sector
The need for the facility on the date given	Meeting the required standards of delivery (i.e. if the project design was unable to provide the required service, the private sector would pay for rectifying the design)
Adequacy of its overall size to meet public service needs	Cost overrun risk during construction. If for example, ground conditions require considerably more extensive foundations, the private sector will cover those extra costs
Possibility of a change in public sector requirements in the future	Completion of the facility on time

holdings in other projects.

Whether standards of delivery (set by the public sector) will meet public needs	Underlying costs to operator of service delivery, and future costs associated with the asset
Extent to which the facility is used or not used over the contract's life	Risk of industrial action or physical damage to the asset
General inflation risk - unitary charges are linked to inflation.	Certain market risks associated with the scheme (for example, on a road scheme, the actual traffic using the road ⁵).

PPP is selective, quantifying certain possibilities and turns them into “risks” while others remain qualitative “uncertainties” (Broadbent et al 2005). Broadbent et al describe this as an “accounting logic”. However, it could be a mistake to assume that possibilities are unquantifiable merely because they are currently unquantified. PPP creates frames for viewing the world; some issues appear and some disappear; some possibilities become countable and others obscure. Indeed, Froud (2003) argues that many possibilities seen under PFI as quantifiable turn out to be radically uncertain. Risk classification is necessarily political: the distinction between qualitative and quantitative is not merely a property of the particular facts under consideration but also of the social context within which they become data, and the questions asked of them.

The possibility of refinancing PFI schemes was simply not considered and measured. But this could have been foreseen; the risks borne by contractors are slanted towards the beginning of the contract, therefore it is logical to expect that following this period financial contracts could be renegotiated to take advantage of the investment’s lowered risk profile. Sadiq Khan MP made this very point (House of Commons Select Committee on Public Accounts 2007:30). Refinancing is scarcely an obscure or difficult concept; home owners frequently refinance their mortgages when market conditions or their personal circumstances change. But given a context in which government wished to reassure the private sector over a new initiative, the responsible state agencies were not interested in measuring and taking precautions to share private sector windfall gains.

⁵ I would argue that in practice, the private sector tends to avoid assuming demand risks – certainly in LIFT this is the case (see above).

The code introduced in 2002 for sharing refinancing gains with the public sector has apparently also had predictable consequences (House of Commons Select Committee on Public Accounts 2007). Instead of refinancing deals, consortia are selling them on the secondary market, there being no requirement for companies to pass on any of the gains made by selling shares in PFI projects. Furthermore, where refinancing does happen, gains made by the public sector often involve additional risk. The Department of Health even requires NHS Trusts to take refinancing proceeds over the life of a contract, putting these gains at risk if the consortium fails (whereas the private sector partner can take all their refinancing gains at once, reducing their incentive to keep the contract going).

In Walker's table it is apparent that a heavy burden remains with the public sector: the state must create and populate contractual structures that will enable the exercise of the "private sector virtues" that it seeks. The public sector must specify the contracts to a high level of detail and accuracy. There is limited room for mistakes or afterthoughts where the service specifications must be made up front for a project lasting twenty-five years or more. And while the risk transfer methodology assumes that the overall risk burden will be the same in a PPP or publicly funded project, it could be argued that PPP amplifies and creates risks rather than diverting them away from the state. Jenkinson (2003) claims that while contracting for private finance makes previously implicit risks explicit, this carries its own costs, particular in complex cases where contracts remain incomplete; and the majority of cases are complex.

Dewatripont and Legros point out that rather than being a result of catastrophic state failure, cost over-runs may actually be functional for public procurement. They could protect the state against worse consequences: "while cost overruns are often viewed as illustrating the failure of traditional public procurement, we have pointed out that they can be equilibrium phenomena. There are costs associated with trying to make contracts complete and specifying a project in such a way that its characteristics will not change later on." (Dewatripont and Legros 2005:141).

While the value for money process assumes an identical project in each case, as Froud (2003:577) points out "Whether PFI is, in fact, cheaper in monetary terms is difficult to assess because the project that results is not necessarily the same as that

which would have been funded using conventional finance.” PFI and LIFT encourage the building of new hospitals and health centres, more profitable than refurbishment projects. In a number of PFI projects, including Walsgrave Hospital in Coventry, the Edinburgh Royal Infirmary, and Norwich and Norfolk University Hospital, city centre sites have been sold off to developers and hospitals relocated to out of town sites. In Plymouth the Derriford Hospital project became a dramatically larger and costlier project in order to attract PFI finance, before being scaled down again after the failure to sign a contract.

Thus the PFI process itself may create increased costs, and increased risks and/or uncertainty. Where hospitals move to out-of-town sites, there are associated environmental and public health costs due to increased reliance on car travel. Out-of-town sites are often inaccessible by foot or by bicycle, and public transport systems are constructed to allow movement into and out of town centres, not to allow movement between out of town sites (e.g. residential suburb to greenfield hospital site). LIFT seems to be producing a similar pattern, although on a smaller scale. For example, in one of the case study boroughs, the PCT recently produced a plan for four LIFT primary care super-centres to serve a population of over 200,000. The borough in question is notorious for its poor transport links within the area and a number of residents’ campaigns have begun campaigning against plans to close local GP surgeries.

Vining and Boardman (2006) found that P3 (PPP in Canada) often involved high transaction costs, which were aggravated by complexity and by firms attempting to transfer risk (e.g. through setting up specialised companies and through maintaining high debt-to-equity ratios). This is a feature of the LIFT arrangements. While there are restrictions on the sale of LIFTCo shares, each individual project or set of bundled projects are not owned by the LIFT Company but by separate FundCos. This enables the development of a secondary market allowing the private sector investors to sell shares in projects without seeking the public sector’s permission⁶, and an interviewee at Partnerships UK confirmed to me that this is intentional.

LIFT and PFI have encouraged the public sector to view risk from the perspective of the “private sector partners”, who prioritise the financial and in particular, shareholder

⁶ Although in the case of LIFT, as the local public sector organisations own a minority shareholding in the FundCos, they would share 20% of the financial gains from such a transaction.

value. A business-friendly discourse has renamed “local health services” as “local health economies”, while NHS Primary Care Trusts’ Health Improvement Plans have been renamed as Strategic Services Development Plans. This signals a shift towards a generic approach to service provision encouraged by the involvement of key private sector personnel with generic business experience but often little specialist health knowledge (Aldred 2007a). This in itself may be viewed as a risky strategy: the NHS has considerable public support and is viewed as (potentially) embodying a widely held ideal, as well as being an actually existing service.

Off the balance sheet: social risks and social regulation

The approach to risk management used in PPP projects “does not lend itself to the incorporation of ... social risk factors” (Hood and McGarvey 2002:27). Partnership for Health’s LIFT guidance focuses on economic assessments, with no recommendation that PCTs or LIFT companies undertake Health Impact Assessments. As accounting entities, NHS Trusts must achieve financial balance or a return on capital employed. In addition, they have clinical targets to meet. A broader public mission may be jeopardised by the presence of PFI or LIFT payments high up the Trust’s priority list. In areas with costly PFI schemes there are reports of plans to downgrade or close remaining non-PFI hospitals; critics argue that such hospitals are facing service cuts primarily because downgrading PFI hospitals saves less money as the PFI consortium would still receive its annual charge (Hellowell and Pollock 2006).

The economic analysis underlying PPP is narrowly contractual and pays little attention to issues of power that can lead to supplier dominance (Lonsdale 2005). This may be particularly important here: buying in the NHS is decentralised, and small teams in Trusts must manage relationships with many firms, most of which have highly sophisticated selling capacities. In the case study area NHS managers responsible for overseeing LIFT – let alone GPs and others – often had trouble understanding how the system worked (Aldred 2007a). Lonsdale argues that a purely economic (in narrow terms) analysis of PFI is misplaced, because (2005:242) “[in PFI] political imperatives often dominate economic rationality.” He gives as an example repeated statements by ministers to the effect that “PFI is the only game in town”. This weakened public sector bodies’ bargaining position vis-à-vis suppliers.

Despite the dominance of economic arguments, proponents argue that LIFT embeds social criteria into decision-making through its risk profile, creating the incentive for private firms to build sustainably and so save on maintenance costs. A National Electronic Library for Health management briefing states that “LIFT schemes offer the opportunity to ensure that new primary care premises contribute towards healthier local economies and a better environment eg local procurement, building to minimise energy use.” (Cawthra 2007). Similarly, one LIFT Company claims: “The relationship between capital, lifecycle and maintenance costs is such that small increases in capital cost can deliver larger savings in lifecycle and maintenance costs, and since LIFTCo is responsible for all these costs there is a clear incentive to optimise ... LIFTCo’s ability to take on development risk (either on its own account or through its private sector partner) ensures that the full development potential of NHS sites can be realised, often in ways that contribute to local regeneration.” (Building Better Health undated).

But firstly, it is possible that a LIFTCo will not act “rationally” in this way, instead relying on its monopoly power and superior bargaining capacity to force concessions from the public sector body over the term of the contract. Given limited liability, private sector investors can walk away and only lose their initial investment. However, the public sector cannot afford to lose health centres and hospitals, and so must always be in a weaker bargaining position, particularly where there is fragmentation of the purchasing agency as in this case. Ball et al (2003:282) state that “there is some evidence to support the assertion that imposing significant penalties where the risk outcome goes against the private contractor is difficult.” They point out that in conventional procurement (where the private sector is commissioned to build a particular building, or supply particular goods, which will then be purchased by the public sector) by no means all risks rest with the public sector, and the risk of being overcharged in the event of a change in client specifications is actually less because of the greater provision of detailed cost and input information.

The PWC (2001) report that planned LIFT states: ‘Given that the joint venture will be substantially owned by the public sector, and that it will be co-ordinating the delivery of certain public services, it will be important to minimise potential for embarrassment arising from its “failure [sic].’ This is a key question as yet unresolved: to what extent will the government allow PPPs responsible for key public services to fail? However,

“embarrassment” structures a power differential into the heart of the partnership relationship. For the private sector, “potential for embarrassment” can represent a key advantage of joint ventures: the de facto assumption of additional risk by the public sector, which cannot allow the joint venture company to fail. The company form is perceived as drawing public sector decision-makers into a position of responsibility. “Failure” most obviously refers to insolvency, but is ambiguous: perhaps it could only mean the imposition of stiff penalties for underperformance, damaging the LIFT Company’s balance sheet? This interpretation is supported by the stern warning at the beginning of Version Five of the Strategic Partnering Agreement:

All parties are reminded that LIFT is a true partnership in every sense of the word and the value of further debate over insubstantial issues should be considered in this light. Both PfH and the public sector shall thereby be positively motivated to work with the private sector to avoid or mitigate the impact of any issues that may arise over the lifetime of the project.

(PfH undated:5)

Secondly, even if this power play does not happen, the risk profile model assumes that wider costs and benefits (a) can and will be described in financial terms and (b) such benefits translate into financial rewards for LIFTCo and/or member organisations. This is not always obvious. PFI hospitals in out of town locations have frequently created large pay car parks, with potential negative impacts on the environment, health, and patients’ finances. However, such car parks have produced revenue for PFI consortia. In one of eight local LIFT surgery planning meetings that I attended, participants briefly discussed sustainable energy production as part of the large centre that was being developed. However, as this would have slightly raised the total costs of the centre, it was not pursued. Similarly, attempts to include community organisations have floundered due to the prioritisation of the financial. Under LIFT, the LIFTCo is responsible for “retail units” in centres and these are normally let out at a profit – hence their alternate designation as “third party income generators”. But the high cost of LIFTCo rents can make it hard to find any tenant, let alone a health-related or voluntary sector one.

Equalities and environmental issues may be marginalised under PFI and LIFT due to its contracting out model and the prioritisation of the financial. There are likely to be equalities issues related to the transfer of low paid support service staff; PFI schemes have arguably had negative effects upon female hospital cleaners, who are predominantly female (UNISON 2003). Such concerns are expunged from the assessment of PPP risks; yet hidden social risks may be bound up with financial risks. Other risks involve the potential loss of integrated control where staff are separated into clinical and non-clinical groups; researchers have argued that this can adversely affect patient care (Pollock 2004). Where the public sector organisation has a broad social remit (including for the NHS health promotion, arguably linked to environmental factors, work environments, and quality provision of ancillary services such as meals), this may remain – like the elusive PFI asset – off-balance sheet.

Additional social risks result from LIFT's financialised logic prioritising the development of one-stop shops rather than more diffuse care networks (Aldred 2007b). Services are co-located for economic benefit to LIFTCo and to PCTs, encouraging the development of commodifiable services. For example, leisure centres are a popular component of larger LIFT centres, as local authority-funded services that can provide long-term, guaranteed revenue. However, attention has recently been drawn to the additional benefits of open-air exercise such as nature walks (Mind 2007). Would the provision of such services from within a LIFT centre conflict with a leisure centre's need to secure income, including from GP-provided "exercise prescriptions"? The current policy steer instead seems to point towards inclusion of traditionally acute-run services and welfare services, which risks primary care becoming increasingly medicalised and bureaucratised (creating a further set of social risks).

As one frustrated private sector consultant argued, there is no value placed on engaging community organisations to support and promote LIFT, so no money was available. This led to legitimisation problems further down the line.

So for example if you don't [fund and support a "social partner"] one of the downsides might be that a local residents group would put in a planning objection and that would have a financial impact on your scheme. Because it may delay it for eighteen months and nothing will happen at all. If you don't get local goodwill

then you're not going to be able to develop the scheme perhaps at all. And there have been some schemes that have been stopped by resident action.

While the “risk society” thesis implies a withdrawal of trust in large institutions, LIFT (even more so than PFI) does not represent a shift from the large to the small. In fact, it is the opposite: the suppression of a managed market or network of small private producers and NHS organisations, and its replacement by corporate-dominated forms. Corporations are major beneficiaries of LIFT, and corporate forms enable the protection of investors through subcontracting and the limitation of liability. However, these forms have been discredited by anti-corporate activism and damage the perceived legitimacy of models such as LIFT, particularly where they are seen to threaten small producers and community organisations.

The detachment and “unreality” (Aldred 2007a) of the LIFT vehicle thus produces problems of embedding and social regulation. The tension within the concept can be seen on the Department of Health website, which oscillates between describing LIFT as a local, long-term partnership and as a temporary device to kick-start investment in which “we can sell our shares”. NHS managers for their part in the case study and comparator areas complained that the private sector did not seem to be bringing additional expertise. They argued that firms’ risk aversion has meant bypassing existing networks of trust in favour of high cost solutions; for example, insisting on a nationally known construction company rather than a local builder.

Elsewhere I have argued that the LIFT model fails to produce governance in the Foucauldian sense, instead relying on a bureaucratic outsourcing model (Aldred 2007b). As organisations become disembedded from their social environment, social regulation suffers, producing unforeseen social risks. For example, Partnerships for Health initially seemed to assume that the involvement of local authorities in LIFT would avoid problems with planning enquiries (Aldred 2007). The “Strategic Partnering Board” and associated structures failed to secure “buy-in” even from the managers running them, with the SPB chair in the case study area commenting that “[t]he input has come from a very small number of people who actually have wanted just to get the show on the road.” There was little “buy-in” from clinicians or the community apparent in the case study and

comparator areas. This makes the organisational structure fragile, in need of constant managerial repair and maintenance.

Power and perspective: whose risks?

Risks and benefits of PPP models such as LIFT seem unevenly distributed. The bulk of “demand risk” is borne by the public sector; a future government that wishes (for example) to dramatically cut the prison population would still have to pay PFI charges (including charges for support services that would not then be provided) for any PFI prisons that it closed. On a more day-to-day basis, public sector managers’ freedom to reconfigure services in LIFT buildings is restricted, compared to publicly owned buildings: the LIFT Company has a monopoly over minor or major alterations over the contract period. By contrast, the private sector gains guaranteed security of income (provided it meets availability targets) while retaining the ability to sell on the project company. This represents a risk reduction for the private sector compared with a “normal” market in which demand cannot be guaranteed, yet this does not appear to be reflected in profit margins.

While PFI is justified by the argument that the state deals badly with risks, the emphasis on risk management through commodification and contract implies that the state is an economic actor in the same way as are firms. Yet the state has responsibilities and powers that are not delegated under PFI: for example, its responsibilities under public sector employment legislation and the Freedom of Information Act. The political direction of the state can at least in theory be radically altered through the ballot box, and private sector companies are rarely willing to take on such unknowable risks: hence the British state’s willingness to indemnify corporations dealing with ‘risky’ countries through the Department of Trade and Industry’s export credits guarantee department. If the contract is to work as a disciplinary mechanism, the public sector must be prepared to allow projects to fail, in order to punish underperforming firms. Yet this is unlikely and arguably socially undesirable.

The public sector shareholding in LIFT companies is intended to regulate NHS managers, encouraging them to see themselves as part of “their” LIFTCo. In addition to enabling risk-taking, the policy is intended to produce changed systems of social

regulation. However, in my research NHS managers made a clear distinction between the NHS and the LIFTCo, with one manager (who had helped to create the company and who in general supported private involvement in the NHS) horrified when I asked her whether she felt part of the LIFTCo. NHS managers felt responsible for the fortunes of the company without feeling that they had control over it. This responsibility without power has been identified as a feature of lower levels of the devolved state (e.g. Pollock 2004).

Meanwhile, the private companies involved enjoyed the converse – power without responsibility. The power imbalance inherent in the local NHS/private sector relationship means that risk is hardly parked “with the party best able to control it”, as is assumed to be optimal (Walker 2005). Local NHS primary care trusts have limited control over their funding allocation, which may be changed by central government. They lack control over the broader determinants of local health, such as income inequalities. Unsurprisingly, most NHS managers whom I interviewed felt alienated from the model: risk seemed here to be disabling rather than enabling social regulation.

This article has characterised LIFT’s risk regime as representing the commodification of risk without its individualisation. Ultimately, risks are not privatised but ultimately remain socially owned, due to the nature of the service, the power relations involved, and (contra Douglas) private sector companies’ – and in particular banks’ – aversion to risk. However, the narrow framework used to consider risk transfer sidelines the consideration of both retained risks and the additional risks generated through the complex contracting arrangements of LIFT and PFI. These arrangements tend to squeeze out the smaller, more locally rooted actors (local pharmacists, GPs, voluntary and community organisations) who perhaps could have helped to ensure local participation in the LIFT planning process. Instead, the failure of the LIFT model to socially embed itself helps to produce and amplify a new set of social risk – and financial risks, given the high costs of the model (UNISON 2006).

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