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Closed policy networks, broken chains of communication and the stories behind an ‘entrepreneurial policy’: The case of NHS Local Improvement Finance Trust (NHS LIFT)

Dr. Rachel E. Aldred

Abstract

This article draws on original case study research to develop more general conclusions about policy-making processes under New Labour. I discuss the Local Improvement Finance Trust (LIFT) as an exemplar of new trends in contemporary capitalist welfare regimes, and I compare some of the enterprise rhetoric surrounding and justifying LIFT to the experiences of National Health Service managers and clinicians in my case study. I consider why many of the voices that I studied appear to remain unheard outside private interviews and meetings, and conclude that changes in the public sector are helping to create closed networks that are unresponsive to concerns expressed ‘on the ground’. Finally, I consider some implications of my data for the future of neo-liberal welfare policies.

Key words

health care, neo-liberalism, privatization

Introduction

As ex-UK Health Minister Alan Milburn told the PPP Forum¹ (Milburn, 2004: 1), ‘PPPs [public–private partnerships] have become embedded as a core part of the government’s modernisation programme for the public services’. PPP is a loose term, but Milburn’s phrase reflects the growing involvement of large private companies at all levels of public service organization in the UK, particularly England. In the National Health Service (NHS), the Private Finance Initiative (PFI) accounts for a large majority of new capital spending on hospitals (Pollock, 2004). PFI involves private sector consortia financing, building and maintaining NHS hospitals, running ‘non-core’ services (which may range from cleaning to pathology). The private sector is being invited to provide previously sacrosanct clinical services; current primary care reforms originally sought to remove direct provision of primary care services from the NHS organizations now running them, primary care trusts (PCTs). Although this has

been partially withdrawn following protests, a key government aspiration remains what is now called 'diversity of provision' in all aspects of health care (Hewitt, 2005).

Alongside this dramatic turn towards PPP in health and welfare financing and provision, there has been a medium-term shift in government discourse about public services. The concept of 'enterprise' is prominent, and social policy is conceived in economic terms (Fairclough, 2000). What role do policy networks play in this development of PPP in practice and theory? And what light can such 'really existing' coalitions shed on the positive features often attached to network organization (Hay, 1998)?

Such questions are highly relevant to the PPP government–industry nexus, as recent years have seen a proliferation of think tanks and other organizations broadly supportive of these developments (from Reform to the New Health Network). Existing organizations have been enrolled into new networks expressing the changing configurations of power (Rhodes, 1997). The UK's public audit body, the National Audit Office (NAO) is a case in point. Auditor General Sir John Bourn's (2003) keynote speech at the PPP Forum argued that:

PFI and PPP are the vehicle of the 21st century. They are the way in which public services will be delivered increasingly in the United Kingdom and throughout the world. . . . It's a great opportunity for all of us to show to the world, that in this area as in so many, what Britain does is of the highest quality that can make a real difference throughout the world.

I would argue that this speech suggests the growth of closed networks surrounding PPP, including senior politicians and managers, but excluding many who will actually have to make policies work. Linked to this are broken chains of communication. Assisted by 'commercial confidentiality' which often keeps the progress of contracts secret, information fails to travel between local and national publics, and the state at different levels. Many war reporters are now 'embedded' within military networks. In an analogous manner, PPP industries create their own networks excluding and/or assimilating potential threats, inhibiting criticism on the domestic front. This article addresses the dysfunctionality of such networks and their role in the development of a flourishing, yet unpopular, policy.

LIFT and the case study

NHS Local Improvement Finance Trust (LIFT), a series of over fifty PPP companies formed to modernize primary care premises, is an ideal example through which to explore such processes. It contains many features that may herald the future development of welfare regimes under advanced neo-liberalism, suggesting some contradiction and discontinuities within these developments. And it may help answer the question of how neo-liberalism has been so successful, despite continued public support for publicly provided welfare.

With these aims in mind, I have conducted an in depth case study of one LIFT area; an early scheme, which progressed to financial close relatively quickly, without any significant opposition being raised. Over the course of twelve months, I interviewed key players in local organizations (four PCTs, one mental health trust, a local authority, the LIFT company, its backers), local general practitioners (GPs) with experience of LIFT, and informants from several other LIFT areas and relevant national organizations (thirty interviews in total). I observed a similar number of local and national meetings and seminars discussing LIFT (some private, some public) and collected a library of related documents. This empirical work is the centrepiece of my doctoral research entitled 'Public-Private Partnerships and the Changing Nature of the "Public" in the Global Economy', which is funded by the Economic and Social Research Council (grant number PTA-030-2003-01709).

The methodology combines ethnography and critical discourse analysis, in order to 'look at interpretations of texts as well as texts themselves, and more generally at how texts practically figure in particular areas of social life' (Fairclough, 2003: 15). This critical realist approach seeks to triangulate data from different sources (interviews, observations, documentary analysis), while anticipating that texts and participants may employ different representations of LIFT, according to their locations within networks and organizations. QSR NVivo 2.0 has been used to store and analyse data; data used in this article have been selected to exemplify recurrent themes in interviewees' talk about LIFT (e.g. risk and flexibility).

LIFT and the reorganization of welfare

The LIFT initiative now covers half of England, with Scotland due to follow. LIFT has many affinities with PFI in its 'design, build and operate' structure. A specially created LIFT company ('LIFTCo') designs, builds and operates health centres, mostly using

debt finance, and leases them back to NHS and other tenants. The LIFT company provides certain services to the building's users. But despite these similarities, LIFT is more radical than PFI, potentially giving the private sector much more control over welfare.

First, LIFT is not merely a contract to build one building, or group of buildings. It involves an 'exclusivity clause' giving a LIFT company an exclusive right to build primary care premises for PCTs in the LIFT area. This exclusivity clause was requested by the private sector during an initial consultation (PWC, 2001). LIFT is intended to be a 'population based scheme', not an 'asset based scheme'. Rather than simply building and managing specific buildings, the private sector will help plan health care strategy for the local area over the 20-year Strategic Partnering Agreement. As the Department of Health's LIFT prospectus states (DH, 2001: 18), it will be 'a partner that will not only deliver and manage services and implement investments, but also work with the local health commissioners and service providers to plan future needs and requirements, and how they can best be delivered'.

Secondly, LIFT involves a public sector shareholding: local NHS bodies will own 20 per cent of the LIFT company, with national PPP Partnerships for Health (PfH) owning another 20 per cent. There are two purposes for this shareholding. It is supposed to encourage a feeling of 'ownership' among public sector managers: although 60 per cent privately owned, LIFT companies are meant to be seen as part of the NHS structure. As a senior manager from PfH told me: 'it's a bit like, why would you own a substantial shareholding in a property development company, and then want to go and ask somebody else to go and develop property for you?'

The public sector shareholding also aims to bring commercial imperatives into the heart of NHS decision-making. Criticisms that this creates a conflict of interest (NAO, 2005) were brushed aside by PfH. Such supporters of LIFT encourage the dissolution of traditional boundaries between the public and the private sector. As one interviewee from a private company involved in LIFT told me, without these close connections 'PCTs would potentially be developing schemes in isolation from the commercial realities of where land is available and how a development might better be brought together with social services' (my emphasis). The public sector shareholding is meant to ensure that NHS bodies think about maximizing profitability: 'The LIFT will also look to maximise third party income; provided there are no ethical or service conflicts' (DH, 2001: 26).

The public sector shareholding ensures that funds are merged; public and private sector capital sits in the same investment vehicle (LIFTCo). Other measures ensure that public and private sector personnel inhabit the same spaces, and move in the same circles. An NHS representative sits on the board of the LIFT company. Conversely, private sector representatives sit on the Strategic Partnering Board which takes a strategic overview of developments across the LIFT area. The Board works to implement a Strategic Services Development Plan, which is to be written by representatives of the LIFT company and the NHS. Senior managers from public and private sectors are present at a range of meetings and events related to LIFT. What PfH call 'double-hatting' is meant to promote managerial identities appropriate to this hybrid space, where the private sector helps plan welfare services, and the public sector thinks 'commercially'.

A new stage of capitalism?

Bob Jessop (1994), among others, has argued that we have entered a new stage of capitalist development characterized by a shift away from the national Keynesian welfare state. This welfare state created no-go areas for private capital such as the NHS, spaces dedicated not to the interests of particular capitalist firms or sectors, but to the reproduction of capitalist society more generally (Gough, 1979). The NHS was never totally separate from private capitalist interests, and in recent times this has increased, with the growing power of Big Pharma² and the contracting out of 'support services'. But for many people it embodies a logic opposed to private capital: providing services for the whole population, with (in theory) no payments or profits involved.

The government's NHS reforms increasingly bring market logics into the service. For 'payment by results', this is obvious: the NHS has been split into providers and purchasers, and purchasers buy procedures from providers. For LIFT, it is not so clear. In a web page aimed at members of the public, the Department of Health (DH, n.d.) presents LIFT as a remedy for market failure, pointing out that in general, individual GPs, rather than the NHS, have owned primary care premises.

But in practice, LIFT may often privatize public assets: in my case study, most projects under way involve a publicly owned site being sold to the private sector. These sites were perceived as easier to access than private sector land: a PCT chief

executive acknowledged that ‘in terms of practically getting the early schemes going, that was the quickest and easiest’. Also, GP-owned premises tend to be smaller, and refurbishing them may be less attractive to the private sector than large-scale new builds. As one NHS manager told me:

‘The construction schemes that we’ve asked LIFT to get involved with, namely around refurbishment, is not something that they push forward very quickly. Because it’s not particularly very profitable, and not what they want to do.’

Furthermore, although transferring buildings from GPs to LIFTCos would not involve the sale of publicly owned assets, it would be part of a growing corporatization or supermarketization of capitalist society. Like privatization, supermarketization is an important trend affecting welfare. When the NHS was set up in 1948, the key countervailing powers were perceived to be privileged professionals. Since then, the pharmaceutical industry has grown massively, now representing some of Britain’s (and the world’s) most powerful companies. Other industries have grown up around the health care sector: in the UK, oligopolistic subcontracting chains dominate the PFI industry; bank, construction and facilities management companies locked in a mutually beneficial embrace.

LIFT companies will be closely connected to the global marketplace. The actual owners of primary care premises are not LIFT companies themselves, but different holding companies (FundCos) within the LIFT company structure. This means, according to the LIFTCo general manager in the case study, that ‘if any one project changes hands, that doesn’t then alter the economics of the others’. The structure is designed to make individual projects easier to sell on the secondary market. As an NAO auditor told me, it made the LIFT structure ‘more commercial’ than PFI; more like a property portfolio than a special purpose vehicle, so more connected to global property markets.

LIFT also represents a shift in the way governments contract with private firms: from short-term, discrete contracts, to long-term, complex and open-ended contracts (Lawson and Taylor-Gooby, 1993). This is linked to the consolidation of markets in public services. The government recently announced a deal to alleviate the two-tier system in the NHS, caused by contractors taking on new staff on worse terms and conditions than employees who transferred from the NHS. The deal was welcomed

by the Business Services' Association representing major contractors: partly because the public sector is footing the £75 million bill, but also because the agreement increases barriers to market entry. Similarly, such companies welcome the long term stability and guaranteed cash flow offered by PPP.

LIFT in practice

Arguments in support of LIFT praise its flexibility: the NAO (2005: 20) claims that LIFT is 'an effective and flexible procurement mechanism'. This fits well with the entrepreneurialist ideology often used to legitimate LIFT. For example, a senior manager from PfH told me that 'typically it's the easiest thing in the world for a primary care trust to identify a need, oh and we have a site, and this is how we're going to do it. And only then do you involve the private sector. LIFT allows the private sector to be involved right from here onwards. To say – well, do you really think that's the right idea? Have you thought about doing this instead?' In this discourse, private companies provide innovative ideas at an early stage in the planning process.

By contrast, the public sector is cast as bureaucratic, old-fashioned and irrational. A private sector representative told me 'Most people in the public sector, the way they do it, they're used to separate organisations, aren't they? You go to the Education Authority for the school, you go to the health people for your health, you go to the local authority for your housing and we've all grown up very used to that kind of structure. And all of those organisations tend to act in a very independent way. Which actually is a bit mad.' A private sector consultant was more forceful: 'the NHS is dying, because they're not able to change – that's what the whole modernisation agenda is about. And those that are able to change and adapt and work with the new opportunities are the ones that will survive. Whereas the ones that will refuse to change are the ones that will inevitably get caught up in the system and will disappear.'

However, talking to local NHS managers and clinicians involved in LIFT, a different picture emerged, casting doubt on the claim that flexibility is a property of the LIFT initiative. Analysts should ask: flexibility for what, and for whom? The LIFT structure allows flexibility for capital to move in and out of holding companies, but this does not equate to flexibility in service provision. GPs were worried about the difficulty of altering a LIFT-owned building; even minor changes must be carried out by the LIFT company. A GP working in a LIFT centre told me: 'There are about two or three of

the rooms need some minor modifications. And the bills that have come back, the estimates that have come back are absolutely exorbitant, in my opinion. To convert a simple room from a storage space into a clinical room isn't a lot of work. A bit of decoration, maybe a bit of carpet, telephone point being put in. And the bill came into the thousands!

Other local interviewees contradicted claims that LIFT breaks down bureaucratic barriers. The 'independent chair' (not attached to the public or private sector shareholders) of the LIFT company board said that in the short term, LIFT is not quicker: 'I think in the short term, it just makes a lot more hoops that you've got to jump through. Because it's one more layer of bureaucracy frankly. But, you know, at the moment, it's the only game in town. If they want new capital facilities, that is the route to get them. There is no alternative that's available.' A local GP commented: 'This is a very, very bureaucratic process. This is significantly and heavily management-led. And all the tenants are kept out of it, until the last moment.' A mental health trust director: 'We find at the moment the process is very slow.' A primary care trust director: 'I do feel [LIFT] has been a lot more complex.'

A primary care trust director was sceptical about the idea that LIFT brought entrepreneurial skills to the NHS: 'They're there to bring in the private sector entrepreneurial approach to development. But I have to say I haven't seen any of that in evidence yet. And I don't have a great deal of confidence that the people that are in place will ever do that.'

Other managers complained that the private sector was excessively cautious, rather than innovative. A local authority 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. And that's what they've continued to want for some time. Because they need to get some sort of quantum before it's worthwhile taking risks. But I'm not sure when we'll ever get to the position where we can actually take these broader risks.' The banks, in particular, were perceived as being risk averse: 'There's something like twenty-five percent performance bonds that are expected [by the banks], where normally, they'd have expected a ten percent performance bond. We're paying for all of that, any insurances and stuff like that' (mental health trust director).

Another example of risk aversion is that in my LIFT case study (and, to my knowledge, in all other areas), LIFTCo does not lease surgery space directly to GPs. Originally, this was the intention: the Department of Health website states '[LIFTCo] will rent accommodation to GPs on a lease basis . . . NHS LIFTs will offer GPs flexible lease arrangements' (DH, n.d.). The PriceWaterhouseCoopers consultation paper 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 could be facilitated by passing an element of demand risk through to the private sector' (PWC, 2001: 18). But instead, PCTs have taken headleases on LIFT properties, and sublet to GPs. The NHS, not the private sector, has been willing and able to offer flexible terms to GPs, but this means that the NHS bears the risk of GPs leaving or defaulting.

Some conclusions

In my case study, I have found evidence to question some of the arguments in support of LIFT. More limited research into another three LIFT areas revealed (to greater or lesser extents) similar issues arising. Rather than 'freeing up enterprise', LIFT creates large, legalistic, and bureaucratic systems, which lock the NHS into particular buildings and services for extended periods of time. However, such concerns have largely failed to reach the public, locally or nationally. Despite the worries expressed by clinicians that I interviewed, neither the British Medical Association nor the Medical Practitioners' Union has taken a stance against LIFT, and I was told that the issue was not discussed at the national conference of Local Medical Committees.

Similarly, the NAO report on LIFT concluded (NAO, 2005: 2) 'at national level LIFT is an attractive way of securing improvements in primary and social care. The local LIFT schemes we have examined appear to be effective and offer value for money.' This is despite worries expressed by a variety of organizations (NAO, 2005: 21): 'Representatives from the National Pharmaceutical Association, the British Dental Association and Local Authorities told us they had concerns over rental costs. There is a common perception from these groups of prospective tenants that the higher cost of LIFT, compared to current rent payments, outweighs the benefits of new, purpose built premises.' Instead, the NAO seems to have privileged the responses of Project Directors and private sector bidders: the people who are most likely to give

favourable accounts. Unusually, two Members of Parliament sitting on the Commons Select Committee for Public Accounts criticized the NAO report (for similar reasons).

When I began the case study, I expected to find that local NHS managers had been ideologically enrolled into the LIFT project. Instead, it appears that the organizational networks surrounding LIFT have developed in a way that muffles criticism or even suggestions for improvement. At a LIFT forum, one speaker said plaintively 'It's very difficult if you've got news about things in LIFT that can be made better – and I am positive about LIFT – to find a forum to discuss them.' Patients' Forums, which replaced Community Health Councils, seem less well equipped to evaluate the effects of government policies. Senior government figures have grown close to senior private sector figures, and partnership is interpreted as silencing criticism as in PfH's (n.d.) stern warning at the start of the LIFT 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.

However, these closed networks and broken chains of communication could cause multiple fissures in the welfare state. They may be leading to crises of effectiveness: in my LIFT case study area, projects have stalled in two out of three primary care trusts. LIFT may also lead to legitimation crises, if it is seen to prioritize private companies' needs over those of the NHS. But the outcome of such crises is far from certain. Colin Leys (2005) has accused the UK government of trying to turn back the clock to a pre-war, market based health system. Crises in the NHS could actually be used to speed up this process, on the grounds that the existing system has failed. Struggles lie ahead over who is to be blamed for increasing financial and political instabilities. They are likely to have implications beyond the UK and the NHS.

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Notes

1. An industry group that promotes the benefits of PPPs.
2. The multinational pharmaceutical industry, which contains some major British companies.

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