

The British Labour Government and the Private Finance Initiative in the National Health Service: A Case of Pragmatic Policy-Making?

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Abstract

In Britain no issue is at present more controversial than the Labour Government's advocacy of 'Public Private Partnerships' or the importation of private capital, managerial techniques and business practices into the public sector. The most important single policy measure here is the Private Finance Initiative, a scheme for the involvement of private sector capital and operating methods in the delivery of the public services. It has been described by the Blair Administration as 'a cornerstone of the Government's modernization program for the public services'. The PFI has been presented as the main policy embodiment of 'New' Labour's and explained as an example of 'policy learning'. This paper provides a critical analysis of the operation of the PFI in the UK National Health Service, contends that the explanation of its adoption in terms of a shift from ideology to pragmatism is misleading and suggests an alternative approach.

Introduction

Countries throughout the western world find their welfare state under pressure and especially so in their healthcare systems. A combination of factors – the pressures of an aging population, the mounting costs of medical technology and drugs, rising expectations and, not least, intensifying budgetary constraints – are propelling governments of all stripes to re-evaluate the bases of their health-delivery systems. The most common response has taken the form of a move towards greater reliance on the private sector and upon market incentives. Nowhere – at least amongst centre-left governments – is this more pronounced than in the UK after the return of Labour to power in 1997.

The future of the public services has been called 'the defining issue of our time' and 'the central question of domestic debate' (Guardian March 21, 2002 leader) and their reform has emerged as the centrepiece of the second Blair Government. According to the Prime Minister, his Government is embarked on 'the biggest reform program in public services for half a century' which he dubbed 'our second term mission' (Blair, July 2001). A 'key element in the Government's strategy for delivering modern, high quality public services and promoting the UK's competitiveness' is the Private Finance Initiative (H.M. Treasury, 2000).¹

The PFI involves a separation between the role of financier and commissioner of public services on the one hand, and its delivery. A public body (central or local government or health authority) commissions a capital investment project (e.g. a new hospital) and a contract is agreed with a private sector consortium (often specially created for the purpose) to provide it. Rather than

¹ 1 The PFI as one (though the most important) item in the wider strategy of promoting 'Public-Private Partnerships'. 'PPP is a generic term used to describe partnerships, which involve more flexible methods of financing and operating facilities and/or services' whilst PFI is 'a particular method of financing private investment' (Centre for Public Services, 2000).

acquiring a new asset the public body obtains the right to a service which the consortium is contractually bound to supply. The crucial area in which the PFI is being implemented is the National Health Service.

The PFI, introduced by the Conservative Major Government in 1992, was initially condemned by the Labour opposition as 'creeping privatisation'. By Labour's return to office it had been embraced with enthusiasm. At present, the bulk of new hospitals and schools being built will be privately owned and leased (usually for 25 years) to the public sector: a historic shift in the boundary between the public and private sector. The Government has hailed the PFI as an example to the rest of the world of how to deliver public services more efficiently and to a higher standard. But this enthusiasm is not shared by the public sector unions, by the medical profession and, indeed, by many within the rank and file of the Labour party.

The paper consists of three sections. The first, after briefly describing the PFI, addresses the question of why, after assailing the PFI in opposition, Labour in office has become a staunch supporter. It outlines the explanation most commonly advanced – that it reflects the party's transformation from 'Old' to 'New' Labour, from ideology to pragmatism, from a dogged insistence upon state provision of public services to a new willingness to co-operate with the private sector: a species of policy learning theory. The second section assesses the explanation by reviewing the specialist literature on PFI schemes within the NHS. It concludes that it does not adequately account for the Blair Government's shift from condemnation to eager espousal of PFI. It relies too heavily on analytically constricting categories of pragmatism and, implicitly, rationality in decision-making and tends to be axiomatic in approach thereby ignoring the evidence of the PFI in practice. The third section suggests an alternative approach, which is multi-factorial in orientation, recognises the extent to which policy choice is 'boundedly rational' and assigns explanatory significance to both electoral considerations and the role of ideas or cognitive categories in decision-making.

1. Why the PFI?

From the founding of the National Health Service in 1949 and until the 1980s the public sector was the monopoly supplier of healthcare within the state system. The Conservative governments of Mrs. Thatcher and John Major experimented with a more market-oriented, competitive approach. In 1990 it introduced the co-called internal market which sought, through various mechanisms, to replicate market relations within the framework of a state provided service. Two years later it launched the Private Finance Initiative. Under traditional public procurement government borrowed to invest in new infrastructure, whereas the PFI establishes a long-term leasing arrangement, under which private consortia borrow the cash to build and run new hospitals and so forth in exchange for annual fees. A private provider of a capital asset enables the NHS to purchase services without the need for the initial capital investment. (Owen and Merna, 1997). There are several different types of PFIs but the most common 'requires the private sector to Design, Build, Finance and Operate (DBFO) facilities, usually for 25 - 35 years. The private sector finances construction and is repaid by the state, in regular payments, for the use of the buildings and services' (Centre for Public Services, 2000).

In 1995 the then shadow health secretary, Margaret Beckett, denounced the PFI as 'totally unacceptable' and as 'the thin end of the wedge of privatisation' (cited in *Health Service Journal*

June 1 1995). By the time Labour was elected in 1997 it had reversed its stance and one of its first measures was to enact legislation stipulating that 'all procurements in the NHS which would involve capital expenditure should normally consider PFI' (Quoted by Boyle and Harrison, 2000: 10). Within two years it was boasting that it had 'revitalised PFI' having extended it to 'sectors like health where it had not worked before'. It had become 'a key tool in helping provide effective and good value public services' (Milburn, 1999a; Smith, Dec. 1999). For renewing the NHS's infrastructure, it had become (in a much-used phrase) 'the only game in town'.

But it is a highly controversial one. Whilst the Government presents the PFI as indispensable to the NHS's modernisation, indeed to its survival as a free and universal service, its critics object that it is threatening that very survival - it is 'privatisation by stealth'. David Hinchliffe, Labour chairman of the House of Commons Health Select Committee predicted 'tremendous opposition' within the Parliamentary Labour Party to the continued enlargement of the private sector's role in the National Health Service. The Government's strategy, if pushed to its logical limits, would amount to as 'a complete betrayal of everything the Labour Party stood for, since the 1940s, when we introduced the National Health Service' adding that this 'would quite frankly cause outrage within mainstream Labour Party circles.' (BBC Radio 4 'On The Record' 24.06.01). John Edmonds, head of the General, Municipal and Boilermakers Union (GMB) – a union which has never historically stood on the left of the labour movement - warned that by his insistence upon the PFI strategy 'Tony Blair threatens to crack the foundations of the Labour party. He has certainly tested the loyalty of Labour party members to destruction' (Guardian September 10, 2001). More worryingly for Labour, in an historically wholly unprecedented series of moves, angry major public sector unions - the GMB, the rail union (RMT), the communication workers union (UCW) and the public services union, (Unison) - have either actually reduced or are giving very serious consideration to reducing affiliation funding to the party. By autumn 2002 the issue came to the boil when a group of public sector unions submitted to Labour's annual Conference a motion calling for a moratorium on any further PFI projects while it commissions an independent review of PFI. In the years since Tony Blair had been elected to head the Labour party in 1994 the leadership had suffered only one defeat at Conference (over the emotive issue of pensions). PFI brought a second as the union motion was backed by 67.19% to 32.81% whilst a statement by Labour's National Executive Committee supportive of PFI was overturned by 53.62% to 45.38%. (Guardian October 1, 2002). Ministers airily waved away the rebuff but the fact that the unions were normally very reluctant to embarrass the Government by inflicting defeats underlined the strength of their feelings over the matter. It will remain perhaps the single most contentious issue in British Labour politics.

Why then did Labour provoke such opposition by reversing its stance on the PFI? The most common explanation sees it as part of the transformation of 'Old Labour' into 'New Labour' – from an 'ideological' to a 'pragmatic' approach to policy choice. Pragmatism is seen as one of the defining features of New Labour's so-called 'Third Way'. The old belief that 'public is always best' has given way to a new openness. The disposition to rely on fixed ideological formulae as guides to policy choice – we are told – has been supplanted by a new pragmatism. 'Pragmatism' is defined here in terms of a 'a technical and hands-on orientation' focusing first on the detail of 'what work' and what can be achieved within 'the constraints of empirical and political realities' (Halpern, 1998). In future policy will be judged by outcomes: what matters is what works. Thus Julian Le Grand Le Grand, a prominent 'New Labourite' academic, has equated the Third Way with an agnosticism as to means: 'the best means are whatever achieves

the best combination of ends, whether the means concerned involve the market, the state or some combination' (Le Grand, 1998). As Tony Blair put it: 'Are we going to force local communities to put up with crumbling Victorian buildings for years and years and years just because we have some ideological objection to a private company building their new hospital?' (Blair Feb. 2002).

Labour's transformation has been seen as part of a much broader movement within European social democracy from state to market-oriented policies: a recognition, according to this school of thought, of the limits of government. Whereas responsibilities for service delivery were previously seen to attach almost exclusively to government, a new determination – partly driven by budgetary constraints – to improve efficiency and effectiveness in the public sector have prompted a willingness to co-operate with commercial operators. As a result 'public-private partnerships are now part of the reality of public services and decision-making in many countries' (Stoker, 1998: 17, 19).

In seeking to account for this scholars have drawn upon theories of 'policy' or 'social learning'. Hall defines learning as ' a deliberate attempt to adjust the goals or techniques of policy in response to past experiences and new information. Learning is indicated when policy changes as the result of such a process.' (Hall, 1993: 278). Policy learning most commonly occurs when 'the standard recipes from past policy experience no longer apply' (Hemerijck and Schludi, 2000). A loss of confidence results: the old levers no longer seem to work, doubts creep in about policies and institutional arrangements which had long been favoured as a matter of course. Such moments of disenchantment 'create political space, windows of time, and political entrepreneurs begin to search out and try new policy prescription' (Goldstein, 1984: 13).

Thus, it has been contended, with the Labour party's long and wearying years in opposition. The experience rendered Labour's leaders more willing to rethink established cognitive categories, to reflect upon the lessons of past policy experience and gear policy more closely to hard evidence. A new generation of 'political entrepreneurs' (notably Tony Blair and Gordon Brown) emerged to take over the party's helm and press ahead with a rapid programme of 'de-ideologisation' and 'modernisation'. Hence Labour's new openness, freed from old ideological fetters, towards the concept of public private partnership. The irrelevant battle of public versus private, Tony Blair asserts, which in the past distracted Labour from 'the real challenge of improving our public service' should now be forgotten. (Blair, 2001).

Labour continues to believe that 'collective provision not the market is the best way of ensuring for the majority the opportunity and security that those at the top take for granted' (Blair, July 2001) - as illustrated by the recent unprecedented boost to health spending. But it also insists on the indispensability of 'modernisation' or 'reform' of the public sector, and this is defined in terms of greater reliance on market disciplines and private sector expertise: hence the importance of public private partnership. 'In some areas the state should remain the direct provider of public goods but elsewhere, and in an increasing number of areas, it should act in partnership with the private sector, purchasing and regulating services which the latter delivers' (H M Treasury 2000. Foreword by the Chief Secretary).

From this perspective New Labour replaced the party's 'historic faith in a command form of service delivery' by enthusiasm for public-private partnerships for practical reasons of efficiency and higher standards. (Bevir and O'Brien, 2001) It is a manifestation of its determination to learn

from the past, to select only such policies that appear likely to work, calculated in terms of anticipated measurable *outcomes*. (Temple, 2000; Le Grand, 1998). In the following section, we test this hypothesis by surveying the findings of research into the application of the PFI to the British National Health Service.

2. Is What Matters What Works?

Britain's 2002 budget, announced in mid-April, was declared the Blair Government's first really 'Labour budget' (Observer, April 21, 2002). An unequivocal commitment was made to the refurbishment of the UK's pivotal collectivist institution, the NHS, by a substantial infusion of new public funds. Labour re-emerged, unambiguously, as a firm proponent of public services, to be delivered according to need and funded by direct taxation. However, at the same time as the role of the public sector as the prime *commissioner* of health care was being emphatically reasserted, the Government announced plans for a major acceleration of the use of the private sector as the *provider* of health care, notably (though by no means exclusively) via 'a vast expansion of the controversial Private Finance Initiative' (Observer, April 21, 2002)²

The key objective, the Government maintains, is the delivery of high quality public services and PFI schemes are only approved where they offer 'best value for money' and 'deliver demonstrable benefits to customers and users of those services' (Smith A, 2000b; H M Treasury 2000). The PFI in fact carries a higher financial cost than conventional public funding since public authorities can borrow more cheaply than the private sector.³ The Government's response is that the higher costs of raising capital privately will be more than wiped out by the efficiency gains.

- PFI/PPPs result in better services, better value for money and efficiency savings.
- The disciplines of the market place ensure that the private sector manages risk better
- The private sector is more innovative in design, construction, maintenance and operation over the life of the contract. (Treasury, 2000).

Hence, the Government argues, PFI allows for the provision of 'more essential services and to higher standard than would otherwise have been the case'. (H M Treasury, 2000. Forward by the Chief Secretary). Determining the extent to which these goals have been attained is an immensely complex procedure and, at this early stage, no hard and fast conclusions are possible. PFI-built hospitals are only now beginning to open, and none has a track record upon which to

² Another important initiative was announced in 2000, the so-called 'Concordat' between the state and private healthcare sectors in which the NHS would purchase services from commercial firms though these would still be delivered free to patients. In April this year the Government stated there would be a virtual doubling in the number of operations to be purchased by the NHS from the private sector for patients, and overseas firms (especially from the US) were to be invited to set up profit-making clinics in Britain to treat NHS patients for free. According to one 'Whitehall source,' 'these are things that the Conservative Party would never have had the nerve to do' (Observer, April 21, 2002).

³ The cost of private-sector finance has been estimated at £1.5m- £2m more for every hundred million borrowed annually than if the NHS borrowed itself. (Will Hutton in Observer December 13, 1998).

base a firm assessment. As a report by the influential health policy research institute, the King's Fund,⁴ comments, 'it will be some time before we have a picture of how PFI schemes are working in the longer term' (Boyle and Harrison, 2000: 16). So any judgments must be tentative and provisional.

The impact of the PFI on the quality of service, usually understood to refer to the ability of the NHS to meet need through appropriate treatment equitably delivered, is very difficult to operationalise and measure. Rather than confronting the problem directly (though we do, from time to time, cite judgments by recognised authorities) we utilise two indicators as proxies:

1. The numbers of skilled personnel available to help in the delivery of health care
2. Capacity: the number of beds (which includes appropriate equipment and facilities) available.

Both these indicators are, of course inputs, but are also clearly associated with the level of outcomes.

Critics claim that the added costs of PFI arrangements have led to reductions in both areas. The Government counters that the money to fund a PFI hospital will not be found 'through shedding staff who are needed....In no way...are clinical services compromised or threatened.' (Department of Health, December 1999). A number of investigations, however, cast doubt upon this. Pollock et al report that 'all of the first wave of PFI hospitals, for which figures are available, involve reductions in the number of beds.' The average reduction is of 31% of current (1995-6) capacity. The British Medical Association estimates that 5,000 beds will be lost to the system once the 38 PFI hospitals, costing more than £3.6 billion, are built. (Pollock, Gaffney and Price, 1999; Gaffney et al., 1999c).) Similarly, the House of Commons Select Committee on Health reported in 1999 that 'the evidence we have received leads us to conclude that on current trends the projected increases in the number of nurses and other clinical staff fall well short of what is required to deal with current shortages and future developments in the NHS' (Health Select Committee, 1999). A more recent survey concluded that 'on average, the cost of paying business to build and service a new hospital [under the PFI] is a 30 per cent reduction in beds. Staff cuts and unsustainable pressure on the remaining doctors and nurses follow' (*Observer*, August 27, 2000).

The Government insists that the PFI is only selected over public procurement after a rigorous analysis of the relative costs. It is a comparative judgment: which promises better value for money, public procurement or PFI. Here we enter a highly technical, complex and indeed murky world. The devil is in the detail but this we shall strive to avoid. Officially, rigorous and objective criteria are used to assess the relative strengths of the two options. All PFI schemes are compared with a notional publicly funded equivalent, the so-called 'public sector comparator' using an appraisal methodology 'under which the cash payments associated with each option are "discounted," and costs are adjusted to reflect "risk transfer."' The public sector comparator takes account 'of risks which under public procurement the public sector carries itself, but which under private finance initiative it pays another agent, the private investor, to bear' (Gaffney et al.,

⁴ The King's Fund is the UK's leading independent health policy research institute.

1999b). These include such risks as construction cost overruns, design faults, higher than expected maintenance costs, unexpected variations in demand and so forth. In almost every case, the methodology has shown PFI to promise better value for money. The reason for this, the Government contends, is that 'the discipline of the market place ensures the private sector can manage risk better - it has better incentives and is better equipped to deliver on time and within budget' (H.M. Treasury, 2000).

However a number of commentators have cast doubt upon the robustness of the appraisal methods used. The key issue is risk transfer: is it accurately costed? Does genuine transfer take place? The significance of the financial calculations entailed in determining risk allocation cannot be overstated: in its evidence to the Health Select Committee, the Department of Health acknowledged that 'the majority of savings provided by PFI are due to risk transfer'. (Boyle and Harrison, 2000: 22). Without this, in most cases, outright public funding would provide better value for money.

The evidence would not appear to substantiate the Government's claim. The best indicator of the extent of risk actually transferred is the interest rates paid by consortia to their lenders. These reflect calculations by lending sources about their precise degree of risk exposure. In PFI schemes surveyed by Gaffney *et al.* they found that borrowing terms were 'extremely favourable' implying modest vulnerability. (Gaffney *et al.*, 1999b; Shaoul, 1999). While the 'whole purpose of the PFI', former Observer editor and economist Will Hutton commented, 'is to off-load government borrowing and risk onto the private sector the private sector regards itself as accepting very little risk' (*Observer*, December 13, 1998).

Indeed, the relatively low level of risk has allowed some PFI firms to capitalise on a 'risk premium' through the development of new risk markets. As risks are progressively reduced once the more "risky" constructing phase of a project is completed PFI contractors are undertaking 'refinancing' deals which enable them borrow at lower interest rates and pocket the difference between the original and new financing costs. As a result a new insurance market in risk has developed as PFI 'risk' has been converted into a commercial product, priced and traded. The Observer reports that 'refinancing can yield windfall profits of tens of millions as the public purse pays "rent" at the old "high-risk" premium' (Observer, 2002).

Some cases (outside of the NHS) suggest that the public may be 'paying a risk premium for a risk which is not actually fully borne by the PFI contractor when the circumstances of the risk materialise.' For example, many of the costs arising from serious delays in the implementation of a new computer system for the UK Passport Office fell on the public, rather than the PFI contractor. (Mayston, 2002). The degree to which, in the real world, risk *can be* transferred in the case of large-sale public sector capital is questionable. As the National Audit Office noted, 'ultimate business risk cannot be transferred to the contractor because if the contractor fails to deliver the specified project, the public sector still has the responsibility for delivering the required public service' (National Audit Office, Nov. 2001). The Government is already bailing out, at a tremendous cost to taxpayers, the privatised railway system though not before rich profits have accrued to private investors. A new hospital be, can no more than the railway system, simply abandoned when a private consortium fails to deliver on its contract. And when voters pronounce judgement governments are not sheltered by limited liability.

The findings surveyed above are not contingent but the result of structural characteristics of the new health market. Economic theory allows us to have a stab at predicting or, at least anticipating, the circumstances and conditions in which goods and services are most efficiently and effectively supplied by the private sector:

1. Where the market for goods and services is sufficiently open and competitive to ensure that producers respond to consumer preferences and prices are fair and reasonable.
2. Where sufficient information is available about the costs, performance and quality of goods and services to enable all parties to economic transactions to make rational judgments.
3. Where transaction costs are low.
4. Where there are no major externalities involved and profit-maximisation by private firms responding to market incentives produces outcomes broadly congruent with the needs and wellbeing of the relevant publics. (Buchanan, 1985: 14-15; Bartlett and Le Grand, 1993: 19) These conditions exist (more or less) in markets for a wide range of goods and services ranging from consumer durables, to food and many services. What of health?

1) Competition

In conventional markets the degree of competition is seen as a key determinant of efficiency, responsiveness and choice. This entails a multiple of providers none able to influence the market price by changing their output. (Bartlett and Le Grand, 1993: 19). 'Competitive tension' in the market for health contracts, the Public Accounts Select Committee stressed, 'is the key both to obtaining and to demonstrating value for money in procurement' (Public Accounts Committee, 1999).

Theoretically, PFI contracts involve the public sector client specifying services which they wish to purchase and, through competition, selecting private sector suppliers to provide them. However, because of the sheer magnitude of the costs incurred by a potential contractor, the number of bidders involved in any one set of project discussions is usually very small. In four of the first fifteen PFI schemes to reach financial close there was only one final bid. (Boyle and Harrison, 2000: 19). The House of Commons Treasury Select Committee acknowledged that, in the real world, 'there is a trade-off between competition and the length and cost of [PFI] negotiations.' (Treasury Select Committee, 2000) Few companies are large enough to cope with the large contracts and complex negotiating processes involved in PFI and the ongoing process of acquisitions and mergers is constantly reducing that number. Even where the procurement was competitive overall, the Treasury Select Committee added, the market 'may be too immature for competitive tension to provide value for money.... In these circumstances, it may not be sufficient to rely only on competitive pressure to secure reasonable financing arrangements' (Treasury Select Committee, March 2000). In short, because of the highly imperfect operations of the competitive mechanism, there are grounds for the supposition that PFI procurement is unlikely to secure the kind of efficiency gains that may be anticipated in a more open and competitive market structure.

2) Information

The conventional assumption of neoclassical economics is that all contracts are mutually beneficial since both parties will normally be equipped with sufficient and symmetrical amounts of information to enable them to reach a mutually advantageous arrangement. As Walsh has pointed out, where this is not the case the possibility then arises that the party with better information will be able to take advantage of the other (Walsh, 1995: 47; 34). Information - and its correlative, expertise and relevant experience - are valuable assets which are often quite costly to acquire. It follows that those organisations which dispose of or can hire more resources are better placed to secure beneficial inputs of skills, expertise and knowledge. Asymmetry in the distribution of information in short upsets the equilibrium that, in the contract process, is supposed under market conditions to prevail. (Walsh, 1995: 47, 11) In PFI contracts there is some limited evidence that this is precisely what is happening. For example, the Public Accounts Select Committee, in its investigation of the PFI contract for the new Dartford and Gravesham Hospital concluded that the Health Trust was poorly informed about the gains the contracting consortium stood to make, exaggerated the likely savings from using the PFI and had failed to calculate the balance of risks and potential rewards (Public Accounts Select Committee, 2000). But the jury is still very much out on this one.⁵

3) Transaction costs

Transaction costs are the costs involved in arranging contracts. They include 'the costs encountered in drafting, negotiating and safeguarding an exchange agreement' and 'the costs of monitoring the outcomes of the exchange to check compliance with the exchange's terms after the transaction has taken place' (Bartlett and Le Grand, 1993: 27). Their magnitude has been recognised as a key issue in determining whether goods and services should be contracted out or handled in-house. (Williamson, 1985). The more effectively contractual performance can be monitored and the more effectively compliance enforced the higher the chances of promised gains being made - a key point where contracts take the form of long-term binding agreements. Transaction costs vary according to the transparency and complexity of the services offered. If the delivery of a service or product can be easily prescribed and monitored contractually, and the standard of the service provided measured with some precision outside tendering may well make sense. This may well apply to such services as refuse collection but much less evidently so in health. (Coulson, 1998: 30).

The more complex and intricate the process of negotiating contracts, the greater the need for developing - or hiring - new forms of expertise. Generally-speaking, NHS Trusts have responded by buying-in services. The expertise required - finance, law and accounting - is generally very expensive. Details obtained through Parliamentary Questions revealed that the advisers' costs of the first fifteen NHS PFI hospitals represented between 2.4% and 8.7% of the capital cost of the projects (Hansard, Written Answer, 28 February, 2000 quoted in Centre for Public Services, 2000). The House of Commons Public Accounts Committee expressed 'alarm' in its report into the Dartford and Gravesham hospital contract that the Health Trust incurred costs from its advisors, KPMG and Nabarro Nathanson which exceeded the initial estimates by almost seven

⁵ A paper written by a senior planner 'right at the heart of the PFI bidding process' and leaked to the journalist George Monbiot reported that contracting companies systematically exaggerated their financial risks and inflated the costs of labour and materials as generously as possible. In some cases, the paper revealed, financial adjustments "slipped

hundred per cent. (Public Accounts Select Committee, 2000). One study concluded that in the early stages of the PFI there was a substantial increase in transactions costs over the level of pre-PFI schemes (Boyle and Harrison, 2000: 19). Heald and Geaughan also suggest that because the PFI process is particularly time-consuming delays have occurred in projects 'beyond the date at which they would have been progressed using conventional procurement' (Heald and Geaughan, 1997: 230).

This may well account for one of the problems troubling the Labour Government's public sector programs: the large amounts of unspent budgetary allocations. The NHS Confederation reported that NHS managers found the PFI to be slow, bureaucratic and requiring 'us to put up a vast amount of management time and consultancy fees at risk without the certainty of success' (Health Select Committee, 1999). And according to the National Audit Office 'there have been in" to the huge and complicated spreadsheets used to calculate how much the government owes. The report concluded that 'without public sector advisers' the opportunities for such practices were 'enormous' (Monbiot, 2002). notable cases where PFI projects have failed or been delayed with significant adverse consequences for the public sector' (National Audit Office, 2001).

4) Externalities

Externalities are costs or benefits not captured by the terms of a contract. By focusing on the costs and benefits of the *immediate contractual relationship* analysts have suggested that PFI schemes tend to discount these wider effects. 'The yardstick for success in the modern world' Alan Milburn the Health Secretary, pointed out is 'whether the services we fund deliver their core purpose' (Milburn A. 1999b) But, according to Boyle and Harrison 'the PFI in its existing form is not a suitable means of delivering on the Government agenda to rebuild the NHS around the planned delivery of health care across a full range of provision facilities' (Boyle and Harrison, 2000: 34). Why is this?

PFI contracts focus on how a set of discrete procedures typically the responsibility of an NHS Trust can be carried out in the most cost-effective way. By encouraging a multiplicity of contractual arrangements amongst a host of autonomous units the Private Finance Initiative contributes to a fragmentation of overall service provision and to a neglect of wider needs whose formal responsibility lies with bodies or agencies not party to a contract. An example would be adequate provision for the elderly which requires close collaboration between suppliers of both primary and community care, responsibility for which is divided between the NHS and local government Social Service Departments. It may make sense for NHS commissioning bodies to make savings by off-loading responsibilities onto other agencies. In short, PFI promotes a view of healthcare delivery that sits uneasily with current strategic policies that treat health care provision as a whole system including care at home and in other community settings. (Boyle and Harrison, 2000: 34) Furthermore, research into the first wave of PFI hospitals indicate that they have had to be heavily subsidised by local health authorities in order to make them affordable. The effect has been to displace costs on to the local health economy reducing the amount left to finance other aspects of health care such as mental health, community services and primary care. (Lister, 2001; Will Hutton in Observer December 13, 1998).

There are also broader and more long-term externalities. The Government insists that under PFI arrangements 'while responsibility for many elements of service delivery may transfer to the private sector the public sector remains responsible for deciding, as the collective purchaser of

public services, on the level of services that are required, and the public sector resources which are available to pay for them.' (H.M. Treasury, 2000). In fact, the commitment of a growing slice of the health budget to meet public contractual responsibilities has quite serious implications for the ability to imprint national priorities, as registered in election contests, upon future spending patterns. A growing share of the resources set aside for healthcare will be pre-committed leaving less and less to the discretion of public authorities and democratic choice. (Pollock et al, 2001). One of the first pieces of legislation passed by the new government was the National Health Service (Private Finance) Act which empowered NHS Trusts to enter into PFI agreements and guarantee financial payments over the life of the contract *irrespective of public expenditure totals*. The Financial Times noted in July 1997 that 'future cash outflows under PFI/PPP contracts are analogous to future debt service requirements under the national debt, and, potentially, more onerous since they commit the public sector to procuring a specified service over a long period of time when it may well have changed its views on how or whether to provide certain core services of the welfare state' (Financial Times, 17 July 1997). PFI contracts will not only limit the ability to switch resources in the future but, in the event of a need to cut spending, force non-PFI expenditure to carry proportionately deeper cuts.

Further, the length of PFI contracts, typically 25-35 years, reduces the capacity of the NHS to respond to fluctuating clinical needs and medical and technological advances. In a review of Labour's first five years, the King's Fund observed that the government 'has rushed into a massive capital building program without any collective or central reflection as to precisely what type of facilities it ought to be investing in'. The Building Futures Group - a collection of leading health and design professionals charged with assessing medical, technological and demographic trends - pointed out that many of the hospitals being built or planned under the PFI might be obsolete long before repayments have been completed under the 25 or 35 year contracts. 'The design of most hospitals and other existing health centres was "disengaged" from the needs of the system'. Though technological and other developments were likely to drastically alter the way in which healthcare is delivered, the Group's chairman commented, under the PFI program 'we are still building institutional hospital buildings that mimic those of the Victorian era and have little to do with the healthcare needs of our children's generation.' (Guardian June 8, 2002; Guardian June 10, 2002). Similarly, Sir Stuart Lipton, the Labour-appointed chairman of the Commission for Architecture and the Built Environment, warned that 'the majority of PFI buildings are poorly designed and will fail to meet the changing demands of this and future generations.' (Observer September 29, 2002)

It is difficult to interpret this as other than a substantial constraint on the ability of future governments to decide 'as the collective purchaser of public services' on how to respond to shifting social needs and new priorities. As Anthony Harrison of the King's Fund points out, 'If the demand for hospital services is reduced for any reason, the NHS trust is still tied into an agreement for maintenance, facilities, and management services over and above the cost of building the hospital. This would not be the case if the hospital was built with public funding' (cited in MacDonald, 2000)

What matters is what works?

The policy learning interpretation hypothesises that the Blair Government's pursuit of the PFI reflects its pragmatism, its refusal to be distracted by ideological shibboleths from measures which evidence and experience instruct offer more efficient and effective delivery of services.

Policy learning, to recall, is conventionally said to occur 'when policy-makers adapt their cognitive understanding of policy development and adjust policy practices on the basis of the knowledge gained from experience' (Hemertijck and van Kersbergen, 1998: 12). However, our summary of the relevant literature indicates that the applicability of the policy learning model to the Blair Government's adoption of the PFI seems limited. Whatever the failings of traditional methods of public procurement there is no reason to believe that the PFI will be any more effective. Indeed, severe doubts about its soundness have been widely articulated in the medical profession. To take a number of examples: Sir Peter Morris, president of the Royal College of Surgeons, warned that within a decade the cost of the PFI to the Health Service would land it 'in desperate trouble' (New Statesman 7 December 2001). Dr Peter Hawker, chairman of the British Medical Association's Consultant's Committee, expressed his anxiety about the PFI's 'poor use of public money' and its 'rash assumptions about work intensity' (Quoted on BBC web site 19 May 1999). To the editor of the UK leading medical journal, the British Medical Journal 'much evidence is accumulating to show that private finance initiative schemes are costing much more than traditional public funding of capital development', with fewer beds and fewer trained medical personnel and 'with the NHS as a whole having to underwrite these extra costs, meaning that resources shift from providers who remain in public ownership to those privately owned undermining still further the goal of greater equity in the NHS' (Smith R 1999b). These doubts were confirmed in an exhaustive survey of reports undertaking cost-benefit analyses of individual PFI projects compiled by the Economics and Statistics section of the House of Commons Library. It found that 'while road and prison projects have achieved reasonable efficiency gains, projects in other sectors such as schools and hospitals have shown minimal gains' (Allen, 2001: 32). And a paper produced jointly by the King's Fund, and the NHS Alliance (representing General Medical Practitioners and others) concluded the evidence that public-private partnerships can increase funding and improve services within the NHS was 'paltry'. (Kmietowicz, 2000).

3. An alternative explanation?

The question then arises of why the PFI option has been pursued by the Blair Government with such alacrity? We suggest that there are a range of relevant factors and that no one explanatory framework encompasses them all. Our discussion here can only be brief and, in the present stage of our understanding, tentative since much more research needs to be conducted before more solidly rooted conclusions can be reached. However, one must start somewhere. It is worth reflecting on why the Major Government launched the policy in 1992. In essence the PFI was devised to allow some capital investment to renew the UK's increasingly obsolete public infrastructure whilst maintaining a tight fiscal stance. In effect it was an accounting device to limit public borrowing via a form of government spending that was 'off-balance-sheet'. Whilst borrowing to fund conventional public procurement was counted as adding to the public sector borrowing requirement, borrowing by the private sector of the same amount of money to finance the same investment, was not - even though the public body would be contractually bound to repay the private firm from its revenue budget. Hence spending was 'off-balance sheet' (Centre for Public services, 2000).

This had an obvious attraction for the incoming Labour Government for it confronted a major dilemma. On the one hand, the coping stone of its strategy for managing the economy was its new fiscal framework, which stipulated a rule-bound system for determining public spending

levels. The object was to facilitate rigorous control over public spending and borrowing.⁶ The device of ‘offbalance- sheet’ accounting seemed a way of allowing the government to reconcile its wish to spend more on capital investment with its commitment to keep a tight fiscal stance. (Guardian, 14 March 2000). The Government also stated that much more substantial investment in the public services (desperately needed after years of Conservative neglect) was *only* compatible with its fiscal framework if, via the PFI, it was ‘off-balance sheet’. Thus the Government claims that a crucial advantage of the PFI is that it has permitted ‘record levels in investment’ in the public sector (Bryan Wilson, Energy minister *Today Program* BBC Radio 4 30 Jan 2002).⁷

However, it has become increasingly evident that much higher levels of public spending, via standard public procurement, *would be* wholly consistent with adherence to the Government’s fiscal framework. Jon Sussex of the Office of Health Economic, and a former Treasury official, concluded that ‘there appear to be no macroeconomic reasons for preferring PFI to Exchequer financing, or for regarding one approach as any more affordable than the other’ (Sussex, 2001). The case for PFI as a means of obtaining extra investment, the Treasury Select Committee agreed, is now ‘very much weaker’ (Treasury Select Committee, 2000). Similarly, Peter Robinson, senior economist at the IPPR (Institute of Public Policy Research, a centre-left think tank close to the Government) argues that the Treasury’s fiscal rules could be easily satisfied without having recourse to the PFI. He dismisses ‘off balance sheet’ financing as ‘little more than an accounting trick’. (Robinson, 2000; 148-9; Guardian October 3, 2002. The report adds that ‘privately, Treasury officials say the PFI projects could be financed conventionally without breaking [Brown’s fiscal] rules’).⁸

Ministers are elected politicians. An interpretative framework commonly used for analyzing policy change derives from rational choice theory. The basic assumption is that politicians are primarily animated by the desire for the enhanced power, status or material satisfaction that the occupation of elective office brings: hence they ‘formulate policies in order to win elections rather than win elections in order to formulate policies’ (Downs, 1957: 28). If policies grounded in a party’s ideology or traditions are vote-losers, then the rational party leader will abandon them. This reasoning has been used to explain social democratic parties’ drift from their ideological moorings. (Koelbe, 1992: 53). However, there is no evidence whatsoever to suggest

⁶ The fiscal framework was intended as both an end in itself, because the Blair Government was convinced that it was a prerequisite of a sustained economic expansion, and - no less important - as a means to win the trust and confidence of the financial markets. The two key components of the framework are: (a) ‘the golden rule’: the Government will borrow only to and not to fund current spending; b) the sustainable investment rule: net public sector debt a proportion of Gross Domestic Product (GDP) will be held at a ‘stable and prudent’ level, which is defined by the Treasury being less than 40 per cent. (H.M. Treasury, 1998a)

⁷ The soundness of off-balance-sheet financing has been widely queried. According to Professor Mayston its use ‘to avoid greater transparency in the long-term obligations that are being incurred, has in the past resulted in substantial financial difficulties for many private and public sector organisations’ – and indeed the Treasury itself has stressed that transparency in the presentation of public financial statements is the ‘indispensable hallmark of good policy’ (Mayston, 2002).

⁸ It may also be that the PFI - which brings direct profits to financial institutions and in which the directing role of the private sector is strong and highly visible - might not send the same alarm bells ringing through the city or the money markets as a large scale public spending program under traditional public procurement. As the Observer commented in its special report on Public Private Partnerships ‘the City loves PFI’ as ‘bankers pocket millions for providing loans’ at low risk.’ (Observer, 2002).

that the initiatives like the PFI involving greater private participation in the delivery of healthcare are popular. To the contrary. The opinion research organisation MORI concluded from its polling that whilst only a minority was opposed in principle to *any* private involvement in the public sector and many were open to persuasion, 'any efforts to move towards a greater role from the private sector are likely to be resisted by a sceptical public' (Atkinson and Jackson, 2001).

But we should by no means dismiss electoral considerations. Ministers constantly reiterate that PFI schemes have made it possible for more hospitals (and other public facilities) to come on-stream more rapidly than would otherwise have been the case without incurring heavier borrowing or having to raise taxation immediately. Timing is crucial here. The Government is avoiding 'the need for capital expenditure at the beginning of project in exchange for making payments for the service as it is delivered, often over a period of up to thirty years' (Treasury Select Committee, 2000). In effect, the full costs are being passed on to the next generation - or to the present generation in their old age (Mayston, 2002).

The extent to which 'the accumulation of additional long-term obligations' for the future is 'an optimal policy of public finance' is, Mayston opines, questionable (Mayston, 2002). However - and this is the crucial point - there is a disjuncture between the repayment cycle and the electoral cycle. Given the massive public pressure to improve health facilities after years of neglect under the Conservatives and given that Labour is *expected* to perform much better on health than its main rival, any failure here will be electorally very costly. The key point - to reiterate - is one of timing. Sussex explains: 'acquiring assets via the PFI is analogous to buying a house with a mortgage rather than paying cash for it up-front. You still have to pay for the house, one way or the other' (Sussex, 2001). Mortgages, of course, are much more expensive than cash up-front. However, long before the repayment schedule has been completed - and the full bill totalled-up - the present ministerial incumbents will have departed the political scene. In short, it makes sense, for the 'rational' (instrumentally minded) politician, to stretch out the payment of the bills even if the final total is much larger.

But there is one other consideration that merits discussion. Policy learning is indeed a relevant factor, once it is understood that such *learning* is not 'a neutral process which takes place in a vacuum of preconceptions and assumptions. What people learn depends on their perceptions of the situation with which they are trying to deal, and the assumptions they bring to bear on problem' (Klein, 2001: 20). The policy learning approach treats policy-making as a never-ending sequence of problem-solving, a cognitive process in which politicians learn from past mistakes, and constantly reflect upon the fit between means, ends and circumstances. But the 'lessons of the past' are never self-evident, the causes of events difficult to disentangle (March and Olsen, 1988: 337). Decision making is 'bounded-rational', that is decision-makers focus on a restricted range of options, take account of only limited account of relevant information about options and rarely delve into all consequences of these alternatives in any methodical manner (March, 1994, 9). Policy-makers inevitably rely on 'cognitive shortcuts: 'decisions are framed by beliefs that define the problem to be addressed, the information that must be collected, and the dimensions that must be evaluated' (March, 1994: 14). This suggests that the counter-position between 'ideological' and 'pragmatic' approaches, if it is taken to assume that a *wholly* rational, objective and rigorous 'evidence-based' policy style is feasible (Temple, 2001: 320) lacks plausibility. Politicians may be more or less open-minded but all must rely on some form of cognitive

shortcuts or framing devices to render problems both intelligible and manageable (March, 1994: 14).

How then do we account for New Labour's paradigm shift? This is a large and difficult question and the research to enable us to answer it has not as yet been undertaken. But Peter Hall has offered a hypothesis which might point us in the right direction. In a conflict of paradigms, Hall argues, 'the outcome will depend, not only on the arguments of competing factions, but on their positional advantages within a broader institutional framework, on the ancillary resources they can command in the relevant conflicts, and on exogenous factors affecting the power of one set of actors to impose its paradigm over others' (Hall, 1993: 280). Since the 1970s, for a range of reasons, the balance of social and economic power has moved strongly in favour of capital and a new orthodoxy – the 'Washington consensus' – has been consolidated, forming 'the overarching terms of policy discourse' (Hall, 1993: 279). Governments operate in an intellectual climate and an institutional environment 'much more conducive to market solutions and much more sceptical of the virtues of the public sector'. They generally now accept as a working assumption that efficiency and effectiveness in the delivery of public services requires a major injection of private sector techniques, norms and practices (Torsteinsen, 1999; Rober, 2000). Freeing service delivery from what is perceived as stifling and enervating public bureaucracy is frequently assumed to be the first step to 'modernising' public organisations. In these circumstances there will be strong pressure on a party leadership eager to take and retain power after a long sojourn in the wilderness – such as the UK Labour party - to bend with the prevailing wind: to adopt what Hall calls a strategy of 'normal policymaking' a process where policy selection occurs within the overall terms of the governing paradigm (Hall, 1993: 279).

Conclusion

The evidence we have surveyed does not substantiate the proposition that Labour's championing of Private Finance Initiative is a matter of determining 'what works' best - of learning from experience and making sound pragmatic judgements on the best evidence available. In their authoritative King's Fund report summarising a mass of evidence Boyle and Harrison conclude that 'the rapid development of the hospital program financed largely through the PFI represents a massive experiment, on which the full evidence will not emerge for decades.... The evidence presented in this paper demonstrates that we cannot be confident that the use of private finance for major hospital schemes is justified' (Boyle and Harrison, May 2000: 39).

As we have seen, the methodology employed to demonstrate the PFI's superiority has been widely queried.⁹ The Government, we would suggest, is convinced that the PFI will work more on axiomatic than on empirical grounds. Indeed, when the Health Select Committee, in an all-party report, concluded 'that further exploration of the impact of PFIs is required before significant levels of recurrent NHS funds are devoted to the servicing of the private capital involved' and advised limiting use of the Initiative to 'a number of pilot schemes until a proper evaluation of the impact on staff and patient care is produced', the advice was not heeded. (Health Select Committee, 1999).

⁹ Prof. David Heald, a top British expert on public finance, has noted that much of the research commissioned by the Government into the relative merits of PFI and public funding has been 'contracted out to consulting firms' with vested interests in arranging PFI deals. (Observer, 2002).

Policy learning does occur but only under conditions of 'bounded rationality'. This is inevitable since unless policy-makers relied on 'cognitive short-cuts', frames of reference which proffer a plausible diagnoses of problems and focus their attention of a limited range of options, decision making would become hopelessly encumbered. They become 'cognitive misers' because, in the press of government business, they have no option. The policy transformation which has taken place with the emergence of 'New Labour' has not taken the form of abandoning traditional social democratic values: to these it still largely adheres. The real change has occurred in the cognitive sphere, in the mode of diagnosis and analysis it favours. It has adopted a frame of reference heavily influenced by the theory of 'new public management' and by the neo-classical economics from which this largely derive: hence the presumption that the public sector can only be revitalised by the 'dynamism, innovation and efficiencies' of the market, and the 'capital, skills and experience' of private investors (H M Treasury).

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