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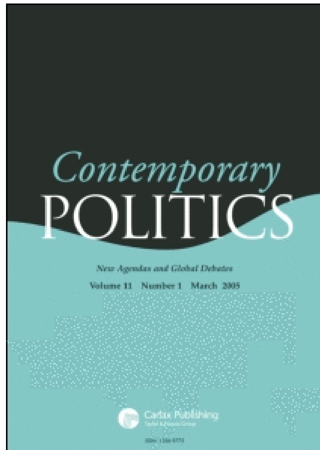

Contemporary Politics
Publication details, including instructions for authors and subscription information:
http://www.informaworld.com/smpp/title~content=t713411554

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Online Publication Date: 01 September 2003
To cite this Article: Shaw, Eric , (2003) 'Privatization by stealth? The Blair government and public-private partnerships in the National Health Service', Contemporary Politics, 9:3, 277 - 292
To link to this article: DOI: 10.1080/1356977032000146051
URL: http://dx.doi.org/10.1080/1356977032000146051

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Contemporary Politics, Volume 9, Number 3, September 2003

Carfax Publishing
Taylor & Francis Group

Privatization by stealth? The Blair government and public–private partnerships in the National Health Service

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Introduction

The reform of the public service has emerged as the centrepiece of the second Blair government: 'Our second term mission', Tony Blair proclaims, 'is to make real and lasting improvements in our public services.' The major mechanism to accomplish this—the 'key element in the Government's strategy for delivering modern, high quality public services'—is the promotion of partnerships between the public and private sectors.[1] Ideology, ministers contend, is obsolete: the precise role of the private sector in the ownership, control and delivery of public services should be a matter of pragmatic judgement—in its catchphrase, 'what counts is what works'. The much greater resources Labour is pouring into the public sector, it is claimed, will produce better services only if modernization is fully implemented—and this entails a much larger role for private companies than ever envisaged in the past.

The National Health Service (NHS) is the jewel in the Labour Party's crown, its proudest accomplishment. 'Labour and the NHS have a common history and a set of common values', Health Secretary Alan Milburn pointed out. 'It is absolute core, heartland policy territory.'[2] The purpose of involving the private sector in public services, he emphasized, was to uphold the NHS as an institution grounded in the public service ethos. 'People like me are pretty wedded to the public service ethos. We believe in it.' It was essential to maintain it 'at all costs because it represents our values'.[3] That ethos, Milburn declared in a formulation that most in the Labour Party would enthusiastically endorse, 'makes the NHS, losing that ethos would break the NHS. We risk the ethos of the NHS, its values and its principles, at our peril.'[4] The object of modernizing the health service by the strategy of partnership between the public and private sectors—the government insists—is to ensure its preservation. But many in the Labour Party claim it will have precisely the opposite effect.

The BBC reported in 2001 that 'the speed at which Labour has embraced the private sector has shocked many in the party'.[5] David Hinchliffe, Labour chairman of the Health Select Committee, predicted 'tremendous opposition' within the Parliamentary Labour Party to the proposed enlargement of the private sector's role in the NHS. The government's strategy, if pushed to its logical limits, would amount to 'a complete betrayal of everything the Labour Party

ISSN 1356-9775 print/ISSN 1469-3631 online/03/030277-16 © 2003 Taylor & Francis Ltd
DOI: 10.1080/1356977032000146051

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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'.[6] To John Edmonds, general secretary of the GMB (the General and Municipal Workers) the partnership strategy constitutes 'backdoor privatisation of the NHS'. Dave Prentis, general secretary of Unison, accused ministers of having a 'depressing obsession and love affair with the private sector' and the union's 2001 annual conference announced a 'national coordinated campaign' of 'strikes, demonstrations and lobbying' against what it dubbed 'the privatisation juggernaut'.[7] The issue provoked a very rare defeat for the leadership at the 2002 conference. More worryingly for Labour, in an historically wholly unprecedented series of moves, major public-sector unions—the GMB, the rail union (RMT), the communication workers union (CWU) and the public services union (Unison)—have either actually reduced or are giving very serious consideration to reducing affiliation funding to the Labour Party.

The issue clearly reaches to the heart of the Labour project. Is 'modernization'—namely the much more extensive involvement of private companies in organizing and delivering public goods—a strategy for adapting the party's traditional values to new realities, or for abandoning them? It is upon this debate that this article focuses. It addresses two main, interrelated, questions:

(i) Will the partnership strategy have the effect of 'further eroding the notion of a public service ethic at precisely the moment when the Government wishes to restore and strengthen it?'[8]
(ii) What light does the pursuit of this strategy shed on the character of the New Labour creed?

The article proceeds in this way. Firstly, it outlines the two main components of the partnership strategy, namely the Private Finance Initiative (PFI) and the increased role of private companies in NHS clinical services—the so-called 'Concordat'.[9] Secondly, it explores the implications of the partnership strategy for the future of the NHS's public service ethos. Finally, it draws some conclusions about the lineaments of New Labour thinking. Does the partnership signify a fundamental shift in the party's values and mode of thinking? Or does it simply represent a pragmatic determination to base policy choice on hard evidence of 'what works'?

The strategy of public–private partnerships

The two key components of the partnership strategy, as presented here, are the PFI and the Concordat. The next section will describe the PFI and review research findings about its impact. The following section outlines the Concordat, though, since it is a much more recent policy innovation, it is not possible to assess its effects. The article then turns to the heart of the matter—the implications of the partnership strategy for the public-sector ethos of the NHS.

Private Finance Initiative

The PFI is a form of financing capital investment. Prior to its introduction, public projects were funded by the Treasury via public procurement. A health authority would submit a bid for a new hospital. If approved, 'a detailed specification was

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drawn up, builders contracted and paid through capital allocations set aside to health authorities for investment projects'.[10] The PFI was launched in November 1992 by John Major's government as a way of making much-needed improvements to the UK's deteriorating public capital infrastructure without adding to the Public Sector Borrowing Requirement. Under the PFI, the public sector contracts to purchase services on a long-term basis from the private sector, which provides capital finance and accepts some of the venture's risks in return for an operator's licence to provide specified service. Within the NHS the PFI involves a consortium of construction companies, bankers and service providers contracting to finance, design, build, maintain and operate new hospital facilities which they then lease to the NHS, usually for periods of 25–35 years. The essential point 'is that the services will be provided by the private sector . . . but funded and regulated by the public sector. The public agencies pay for the infrastructure used to deliver the services and the services themselves via an annual charge.'[11]

Initially, the PFI was deplored by Labour, when in opposition, as the thin end of the wedge of privatization. An official report issued in 1995 warned that the expansion of PFI arrangements put the 'founding tenets of the NHS' at risk and admonished the Conservative government for 'destroying by design or default the service people most value'.[12] In practice, for a range of reasons, few PFI-financed investment schemes had been launched by the time the next election was held. However, rather than calling for its demise, Labour's 1997 manifesto pledged to 'reinvigorate the PFI'. This pledge has been fully delivered: although the idea was devised by the Conservatives, only under the Blair government has it emerged as a major plank of policy. Thus, 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.[13] The health research institute, the King's Fund, calculated in 2000 that by the end of 2002 £1.4 billion of NHS hospital structure would be financed and managed by the private sector, representing 'a considerable proportion of the total value of NHS hospital capital', and with an additional £2 billion on stream.[14]

Critics within the Labour Party have forcefully attacked the PFI. According to Unison leader Dave Prentis, 'the government is relentlessly pursuing a policy that wastes money, wastes time and failed any objective test of value for money'. Using PFI to pay for schools and hospitals was like 'paying for a mortgage through Barclaycard'.[15] The government, however, rejects these criticisms as inspired by a combination of dogma and producer self-interest.[16] The PFI, it insists, will bring practical benefits.

The macro case

The key advantage of PFI here, it is claimed, is that it allows funds to be raised privately, which cannot be raised publicly because of expenditure constraints. Because PFI spending does not count as capital spending it can be moved 'off balance sheet'. 'Substituting private for public finance is seen as a way of taking expenditure out of the public accounts at a time when considerable emphasis is placed upon the need to contain public expenditure.'[17] A similar level of capital

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investment via traditional public procurement would both greatly add to overall spending totals and breach Gordon Brown's fiscal rules, the cornerstone of his economic strategy.[18] In short, PFI has permitted the government to undertake a much more extensive hospital (and school) building programme than would otherwise have been possible.

Experts tend not to give much credence to these arguments. Jon Sussex, of the Office of Health Economics, dismisses the proposition that the PFI permits more investment than conventional Exchequer financing as 'a red herring'. Projects will still have to be funded by tax revenues. 'Given the government's current tests of fiscal prudence, 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.' 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.[19] He dismisses 'off balance sheet' financing as 'little more than an accounting trick'.[20] The use of the PFI simply means the retiming of when the Exchequer incurs the cost—unless there are genuine efficiency gains arising from private-sector involvement.[21] It is upon precisely this that the government places most emphasis.

The micro case

The PFI, the government explains, enables the public sector to benefit from the private sector's 'commercial dynamism, innovation and efficiencies', providing better value for money leading to 'more essential services and to a higher standard than would otherwise have been the case'.[22] The government agrees that the costs of raising private capital are greater than public borrowing (since interest charges are higher) but is adamant that these will be more than wiped out by efficiency gains. These will be procured by (i) greater private-sector access to relevant expertise and experience, (ii) the incentive to minimize costs imposed by operating within a commercial environment, and (iii) significant performance improvement through private-sector innovation and management skills.[23] The proof of the pudding is in the eating: private finance schemes, Milburn insisted, are 'delivering the goods' in terms of 'more modern schools and hospitals built more quickly for communities sometimes that have been waiting for them for decades'.[24]

Although it will be some time before a full picture of how PFI schemes are working, a range of experts have reached provisional conclusions.[25] 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 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'.[26] A memorandum submitted by the Royal College of Nursing to the Select Committee on Health judged that

> the economic case for PFI has not been made. There is concern that the method of costing a traditionally procured hospital is over-inflated; that the argument that PFI passes financial risk from the NHS to the

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> private sector has been exaggerated; and that the total costs to the NHS over the term of a PFI contract are excessive.

In larger (but not smaller) operational PFI sites it found that bed numbers had been reduced, patient throughput had increased and staff workloads had become heavier. In some sites this had been 'identified as a cause of increased staff sickness and lower morale'. Though 'the extent to which these factors impact on the quality of patient care is difficult to judge', there were reports of 'inappropriate early discharges, increased readmission rates and increased demands on community staff'. In light of its findings, the Royal College of Nursing called for the suspension of 'all non-operational large-scale PFI schemes concerned with centralisation, rationalisation and redevelopment of NHS services' and for 'a robust independent evaluation of PFI schemes'.[27]

Similarly, a paper produced jointly by the King's Fund and the NHS Alliance (representing Primary Care Groups, GPs and other community health providers) judged the evidence that public–private partnerships can increase funding and improve services within the NHS as 'paltry'.[28] Finally, in their authoritative King's Fund report summarizing a mass of evidence, Boyle and Harrison conclude that

> the rapid development of the hospital programme 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.[29]

Not surprisingly, there is mounting concern within the medical profession. Dr Peter Hawker, chairman of the British Medical Association's Consultants' Committee, expressed his anxiety about the PFI's 'poor use of public money' and its 'rash assumptions about work intensity'. According to Richard Smith, the editor of the prestigious *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'. 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'[30]

Concordat

If the PFI was an idea inherited from the Conservatives, the Blair government can claim principal authorship of the Concordat, although this too is built on its predecessor's inheritance. The Concordat was the term given to an agreement signed in October 2000 with the Independent Healthcare Association representing the commercial health sector. It was expressly designed to sweep away 'ideological barriers' to the participation of private firms in the delivery of free healthcare within the NHS.[31] Included within the agreement were provisions for:

- renting spare operating theatres from the private sector for hip operations and

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other elective surgery by NHS doctors and nurses working under their normal NHS contracts;
- commissioning private- or voluntary-sector hospitals to provide elective care, using their own staff;
- agreements for transfer of critical care patients between sectors, reducing the number of cancelled operations;
- joint work to develop intermediate care to improve preventive and rehabilitation services.[32]

As a practical measure to ease the pressure on the NHS and drive down backlogs in NHS waiting lists by using spare capacity in the private sector the move was uncontroversial and broadly welcomed by the public-sector unions and the medical profession, including the NHS Consultants' Association—a body representing consultants committed to working exclusively within the NHS. However, it soon became plain that the Concordat amounted to a long-term shift in strategic direction. This was reaffirmed by Labour's manifesto for the 2001 election. It pledged to create 20 new treatment centres under a partnership between the NHS and private sector to carry out hip, cataract, hernia and cardiac operations and envisaged some of the centres being run by BUPA and other private providers.[33] Far from representing a short-term expedient, the use of private hospitals to treat NHS patients represented a permanent new arrangement. 'These new providers', Alan Milburn affirmed in a speech to the NHS Confederation conference 'will become a permanent feature of the new NHS landscape'. This was not intended as a 'temporary measure' but a 'fundamental change' in the organisation of the health service.[34]

The partnership strategy and the NHS ethos

Although the 'public service ethos' is frequently invoked, the concept is rarely defined. The Public Administration Select Committee characterizes

> an ethos as a principled framework for action, something that describes the general character of an organisation, but which, and more importantly, should also motivate those who belong to it ... We see the ethos essentially as a benchmark, against which public service workers and institutions should continuously strive to measure themselves.[35]

Within the NHS it can be seen to encapsulate the three principles of professionalism, altruism and service to the community as a whole. The first refers to work governed by a professional code of conduct, which typically lays emphasis on appropriate specialist training, expert knowledge certified by formal qualification and treatment of one's job as a vocation as well as a source of remuneration. The second is defined by the *Shorter Oxford Dictionary* as 'regard for others as a principle of action'. The third holds that services should be delivered according to need and upon an equitable basis and that considerations of immediate pecuniary gain should have no part to play in service delivery.

Public-sector reform, Charles Clarke—then Minister without Portfolio—affirmed, 'must always respect the powerful public service ethos ... The ethos of public service is as intrinsic to public service as the practice itself, helping to create and manage the expectations and aspirations of all stakeholders.'[36] How-

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ever, the government also wishes to remodel the culture of public-sector organizations along the lines of private companies.[37] Are these two goals compatible?

Answering this question requires deriving from the NHS public service ethos a list of operational values or principles. These we draw from the NHS Plan, the major statement of government health policy:

1. The NHS will provide a universal service for all based on clinical need, not ability to pay.
2. The NHS will provide access to a comprehensive range of services throughout primary and community healthcare, intermediate care and hospital based care.
3. The NHS will shape its services around the needs and preferences of individual patients, their families and their carers.[38]

To what extent is the partnership strategy compatible with these principles? We firstly discuss the impact of the PFI on the ability of the NHS to provide a comprehensive range of services, and plan for the overall health needs of the population as a whole. Secondly, we explore the effect of the Concordat upon the ability of the NHS to give primacy, in its delivery of healthcare, to the clinical needs of patients.

The PFI and the collective determination of health needs

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', as well as 'safeguarding wider public interests'.[39] However, Clarke *et al*. have hypothesized that the shift towards contractual, competitive and calculative relationships will have the effect of fragmenting 'both service areas and notions of collective or public interest'.[40] Preliminary findings appear to substantiate this.

Firstly, in negotiating its contracts each NHS Trust has the incentive to concentrate on ensuring that the activities and procedures which fall within its specific areas of responsibility are arranged in the most cost-effective way, rather than giving systematic consideration to the wider health needs of the population in its vicinity. An analysis of the business plans approved by the Department of Health 'indicates that the 32 hospitals being built under the private finance initiative have been planned not on the basis of health care needs but on the basis of local affordability and cash savings from the revenue budget'.[41] Similarly, by encouraging a multiplicity of contractual arrangements amongst a host of autonomous units, the PPI 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 given contract.[42]

Secondly, 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 (generally positive) review of Labour's first five years, the King's Fund observed that the government 'has rushed into a massive capital building programme 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

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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 25–35-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 that under the PFI programme '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'.[43] Shortly afterwards, Sir Stuart Lipton, the Labour-appointed chairman of the Commission for Architecture and the Built Environment, warned that many of the hospitals and schools built under the government's £43 billion PFI would be obsolete within a few years: 'the majority of PFI buildings are poorly designed and will fail to meet the changing demands of this and future generations'.[44]

Boyle and Harrison, in their King's Fund report, concluded that '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'. Indeed, doubt attaches to the extent that the NHS will retain the ability to take 'a strategic overview of health service provision within a framework accountable to the public at large'.[45] In short, the PFI is likely to weaken the ability of the NHS to undertake nation-wide and community-wide health planning and foster universal standards of provision.

The Concordat and the primacy of clinical need

NHS values, as defined by Milburn, never of course entirely permeated the NHS even prior to the Conservative reforms. To secure the backing of the representative institutions of the consultants (the Royal Colleges), Bevan agreed that NHS contracts should allow consultants the right to engage in private practice.[46] This has been a persistent source of resentment within Labour Party circles—increasingly so with the expansion in private practice under the Conservatives.[47] In 2000, the Health Select Committee compiled a report on consultants' contracts. It concluded that 'while causation and proof are hard to establish beyond doubt in this matter', two facts are not disputed:

> The first is the correlation noted in the [Health] Department's evidence between those specialties with the longest waiting lists, and those which produce the most lucrative earnings for consultants in the private sector. The second is the finding of the Audit Commission in 1995 that 'the 25% of consultants who do the most private work carry out less NHS work than their colleagues'.[48]

In its 2002 report the Select Committee, referring it its earlier findings, commented that 'in our view, too much onus is placed on individual consultants themselves to keep competing interests apart'.[49] Critics suggest that the establishment under the Concordat of a *long-term* contractual relationship (under which NHS patients are treated by private firms) might actually intensify these conflicts of interest by, in effect, rewarding the more pecuniary-minded specialists. Why is this?

It seems very probable that large commercial organizations, increasingly drawn to the potentially profitable new markets opened up by the Concordat,

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will seek to recruit high-quality medical staff by offering competitive salaries and conditions. The only source of such recruits is the NHS. Thus, though the public sector will be training an increasing number of doctors, a significant proportion of them could well be lured to the private sector because of higher earnings potential and a less demanding workload. Given that the ultimate scarcity at present is full-time medical specialist staff, the effect of a long-term arrangement may actually be self-defeating: 'incentives that would persuade [NHS] clinicians to undertake extra activity within the independent sector in order to ease pressures on the NHS' would have 'the perverse effect *of taking staff away from the NHS*'.[50] Furthermore, the types of procedures which fall within the ambit of Concordat contracts will almost certainly be of the more routine, less demanding character.[51] Given that senior medical personnel will be more highly remunerated for Concordat work, the effect is to create a *disincentive* for giving priority to clinical need. Furthermore, as the NHS Consultants' Association report comments, those specialists involved in working under Concordat contracts will not be 'available for ward and post-operative care on patients in their own hospital nor for the supervision and training of junior doctors', again with an adverse effect on the primacy of clinical need.[52]

The eventual effect may be to tilt the balance—which has always existed in NHS culture—away from professional and altruistic towards more commercial and instrumental motivations. In effect, the Concordat provides an incentive to those prepared to place income-maximization—the economizing of money, time and effort—over a general sense of social or professional responsibility. The effect, in time, may be to erode those social norms that restrain people from seeking to maximize their immediate and personal satisfactions—though since cultures evolve more slowly than institutions, changes will only gradually become evident. Commercialization, Hirsch argues, when not appropriately restrained, 'embodies its own dynamic', via the 'tipping' effect: a process in which discrete acts based on individual preferences produce 'a chain of reactions that works itself out only after culminating in a pattern that no single individual would himself choose'.[53] The increasing permeation of an institution by market relations and patterns of behaviour will tend 'to drive out previous patterns of co-operation', and create 'clearer differences of interest and incentives to pursue interests'.[54] In Hampshire-Monk's words, 'the market behaviour of rational egoists might constitute a kind of moral "Gresham's law" undermining and driving out "good behaviour"'.[55] The point is not that complete commercialization will occur—the influence of other factors, including recruitment and training, socialization, professional ethics, workplace norms and so forth, will persist. However, as the *modus operandi* of the public sector comes to more closely resemble that of the private sector, as relations between the providers and recipients of a good or service become more impersonal or 'commodified', a more competitive spirit and a greater sense of calculative (rather than normative) involvement will tend in due course, and with the steady passage of time, to corrode what Hoggett has called the 'lateral solidarities linking service user to service user, worker to worker and professional to professional'.[56]

The partnership strategy and New Labour policy paradigm

The key factor impelling policy makers to opt for one line of action rather than another is less often a detached and meticulously analysed assessment of 'what

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works best' than it is their 'subjective view of the situation' and the way in which they 'characterise the choice situations that face them':[57] in short, their paradigmatic assumptions and beliefs about why some things work better than others. Our object here is not to elucidate the reasons why the Blair government opted for the partnership strategy[58] but to assess what its choice tells us about its underlying policy paradigm. Here we will suggest that Labour's paradigmatic thinking has undergone a profound modification in its attitude to the public domain and to the public (non-market) provision of services.

The Blair government has been much more insistent than its predecessor in holding that the state retains an obligation for providing goods and services in key areas and—crucially—that public bodies have adequate resources to discharge it. Labour's 2002 budget offered a substantial infusion of new public funds to be financed by a significant rise in direct taxation, thereby terminating a squeeze on NHS budgets which has persisted for two decades. Whatever its reservations about the public sector, it shares none of the ingrained, ideologically grounded hostility displayed by the Conservatives. New Labour has re-emerged unambiguously as an ardent proponent of public services, to be delivered according to need and funded by direct taxation.

Nevertheless, there has been a considerable degree of continuity with policies followed by its predecessor. The Blair government inherited public services that were in the process of being 'reinvented', with increasing reliance on contracts and markets. The strategy was designed to transform public authorities into 'enabling' organizations, 'responsible for ensuring that public services are delivered, rather than producing them directly itself'.[59] This strategy, Stoker argues, reflects a much broader movement within European social democracy from state- to market-oriented policies. Whereas responsibilities for service delivery were previously seen to attach almost exclusively to government, a new determination to improve efficiency and effectiveness in the public sector has prompted a willingness to co-operate with commercial operators.[60] From this perspective the partnership strategy is best understood as an awareness that, in a world of constrained resources where demands upon public services are continually intensifying, priority must be given to those policies and institutional arrangements which best guarantee efficiency, value for money and a higher quality of services—whatever their provenance. This does not mean an abandonment of core party values—rather, the adoption of a much more open-minded and rigorously empirical approach to realizing them.[61]

The clash between escalating demands and rising costs on the one hand, and strictly delimited resources on the other, remains a fundamental feature of public policy; thus, combining more efficient resource use with improved quality of service provision is bound to be an imperative for any government. The partnership strategy shows that, for the Blair government, a key to resolving the conundrum is the introduction of market-like mechanisms and private corporate techniques. This can be defined as market replication, 'the creation of regimes which mimic as far as possible the competition and discipline of markets'.[62] The commercial enterprise is regarded as the preferred model of institutional organization, the most efficient and effective way of delivering goods and services. In the past, Labour believed that the intrusion of commercial and competitive principles into the public services would be detrimental to equity, accountability and the primacy of social need in the allocation of resources. Now

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there is a clear shift in outlook. The underlying rationale is that the public sector suffers from endemic failures—a tendency to bureaucratic inertia, a wasteful use of resources, over-centralization, incompetent management, poor motivation and low commitment. The qualities of creativity and enterprise, willingness to take responsibility and to experiment are assumed to be found more commonly in the private sector. 'Compared with the experience of the private sector', one cabinet minister has written, 'services in local hospitals, schools and councils were often too slow and inadequate. Much of this was due to a bureaucratic and statist regime of control and command.'[63] People in the public sector, as the prime minister explained, tended to be sluggish, unimaginative and reluctant to experiment: the techniques of the private sector will stimulate risk taking, a zeal to innovate and a firmer resolve to eliminate waste.[64] In contrast, profit seeking imparts to the private sector an incentive to cut costs and to innovate which 'can lead to better value services, delivered more flexibly and to a higher standard'. Profit maximization and performance-related financial rewards offer potent inducements for management and employees 'to maximise efficiency and take full advantage of opportunities'. By the same token, 'the disciplines, incentives, skills and expertise of the private sector can help release the full potential of the people, knowledge and assets in the public sector'.[65] In short, New Labour holds it to be more or less axiomatic that greater private-sector involvement in the organization, running and even delivery of public services will lead to a substantial boost in the quality of service delivery.

'Modernization' has increasingly become equated with the remodelling of public institutions along private-sector, market lines. As the Labour MP Alan Whitehead observed, 'we have (almost) got to the position where the market itself determines the boundaries of discussion'. If a public institution 'fails' the reflex action is to urge some form of private ownership or management. 'The question posed is not now "are markets a good thing in public service delivery?" but "how can [name of policy] be best improved by market mechanisms".' Hence the tendency to assume that weaknesses in organization can best be remedied by the introduction (where feasible) of 'contracts, cost centres, performance indicators, compulsory competition and so on into the public sector'.[66]

New Labour makes a sharp distinction between the supply via the state of services free at the point of use and their actual delivery. The choice of precisely how a service should be produced is a matter of *means* not *ends*. 'Most third-wayers', Le Grand has commented, 'are agnostic 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'.[67] Thus the partnership strategy is presented by Milburn as a 'third way' alternative to the 'dogma of the right' that 'insisted that the private sector should be the owner and provider of public services', and the 'dogma of the left' that insisted the state must be the sole provider.[68] 'NHS healthcare no longer needs to always be delivered exclusively by line-managed NHS organisations', he elaborated. 'The task of managing the NHS becomes one of overseeing a system, not running an organisation.'[69]

Past Labour thinking adhered to the view that the public sector embodied certain prototypical qualities that distinguished it from the private, with its own operating logic and ethos, which should be preserved from the incursions of the market. It was regarded as 'a vital expression of our communal life, which it consolidates and nurtures' reflecting a 'collective commitment that basic condi-

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tions of the good life should be available equally to all our citizens'.[70] It was seen to compose an arena with 'its own distinctive culture—a culture of citizenship and equity' within which 'the values of professionalism, equity and service rank higher than the calculating self-interest of the market'.[71] It embodied the ultimate belief, as articulated by Tawney, that the 'the way in which society organises and structures its social institutions—and particularly its health and welfare systems—can encourage or discourage the altruistic in man'.[72]

For the Blair government, all this is cobweb thinking. What matters to the public is not who owns what but 'better quality, more responsive public services'. 'For this Government', ministers constantly affirm, 'the key test is what works.' This—Milburn insists—'is where PFI fits in'. It guarantees in the public sector 'what the private sector has long expected to be the norm—modern, well-designed purpose-built buildings that maximise savings over the whole life of the project'.[73]

To the government it is virtually a self-evident truth that private-sector involvement in public services raises standards and saves money. However, as we have seen, the evidence does not support this proposition. A recent report in new school construction by the Audit Commission—the highly regarded public spending watchdog—rammed the message home. The first schools built under the controversial PFI were 'significantly worse' than other new schools in England, in terms of space, heating, lighting and acoustics. There was little evidence of design innovation or faster delivery. 'This study of the early school schemes', the Audit Commission concluded, 'shows that the current process *cannot guarantee, as a matter of course*, better quality buildings and services, or lower unit costs.'[74]

If a service could be equally well delivered by either, does it matter whether the provider is a public or private commercial organization? According to the Public Administration Select Committee it does.

> Whatever the shortcomings of the public sector as it is, there is something necessary, special and distinctive about those services which are provided as public services. They carry with them intrinsic assumptions about equity, access and accountability . . . There is something that links many of these services indissolubly to public bodies and public decision-making. The public realm, of collectively provided services and functions, needs to be recognised for what it is—an essential component of a good society. This is why these services need to work well.[75]

From this perspective, the development of a strong and autonomous public domain, enshrining a set of public principles, is a valued end in itself. The logic of the partnership strategy which disregards these principles is 'the enthronement of market values in public provision', a regime in which 'considerations of public health, clinical need and patient care' will be progressively subordinated to the values of 'cost reduction, operational efficiency and the need to reproduce the managerial culture of a privately-owned PLC'.[76]

Conclusion

To the government, the partnership strategy is primarily an instrument of modernization, supplying mechanisms for the raising of the quality of care

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and allowing more efficient utilization of resources. New Labour, from this perspective, differs from what it chooses to call 'Old Labour' in that it is not inhibited by outdated ideological formulae. The old battle-line of public versus private is an irrelevant one, which has only served to distract the party from 'the real challenge of improving our public services'.[77] The old nostrums are irrelevant because 'in the modern world, governments are judged not on what they own, or on how much they spend, but on whether they deliver'.[78] 'What matters is what works.'

However, sifting the available evidence, we have shown that it is not self-evidently the case that the two key policy instruments—the PFI and the Concordat—do 'work', in the sense that they are the best means of attaining their postulated goals. In some ways they do represent advances and few dissent from the latter as a short-term measure in plugging the gaps in NHS provision. But the partnership *strategy* is precisely that—*a long-term strategy* for remedying the problems of the NHS. As such, we have indicated, it is likely to effect wide-ranging changes in the character of the NHS, ones which pose a challenge to what have been accepted as its fundamental tenets since its founding in 1949. Thus, in the future, while the roles of setting broad policy parameters (though within new contractual constraints) and of purchasing healthcare will remain a public responsibility, the delivery of healthcare will be increasingly dispersed among competing private and public suppliers.

We suggest that this mode of reasoning constitutes a qualitative—or paradigmatic—shift in Labour Party thinking. As the government rightly points out, 'this new partnership approach' constitutes 'a fundamental shift of thinking, putting behind us the ideology and dogma of the past'.[79] It registers a distancing from the concept of the public domain as a sphere of activity with an ethos, working methods and motivational patterns that sets it apart from the private sector. 'The field in which the claims of individual commercialism', wrote Nye Bevan, 'come into most immediate conflict with reputable notions of social values is that of health.'[80] The view that market mechanisms and the commercial ethos cannot be reconciled with the core principles of the NHS—in the past a presupposition of Labour policy making—is no longer accepted as valid.

One should beware of exaggerating the degree to which New Labour has departed from past policy postulates. It retains Labour's traditional commitment to the free delivery of healthcare, and—one must emphasize—an unprecedented volume of resources is now being invested into its renewal. But if the Blair government still espouses a large public sector it is one increasingly permeated by market arrangements and a more commercial—or 'entrepreneurial'—mentality. 'Social democracy and the public domain', Marquand has written, 'are inextricably intertwined ... without a vibrant public domain, ring-fenced from the market and private domains, social democratic politics cannot flourish.'[81] To a large extent this represented an axiom of policy for past Labour governments, but it is no longer so for the present one.

Notes

1. Blair Tony, Speech on Public Service Reform, October 2001.
2. *Observer*, 23 July 2000.
3. *New Statesman*, 20 July 2001.

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4. A. Milburn, Speech to the NHS Confederation conference, July 2001.
5. BBC Radio 4, *On the Record*, 24 June 2001.
6. BBC Radio 4, *On the Record*, 24 June 2001.
7. *Ananova*, 15 January 2002 (Edmonds); *Guardian*, 21 June 2002 (Prentis).
8. David J. Hunter, 'A Tale of Two Tribes: The Tension between Managerial and Professional Values', in Bill New and Julia Neuberger (eds), *Hidden Assets*, London, 2002, p. 66. See also Torben Beck Jørgensen and Barry Bozeman, 'Public Values Lost? Comparing Cases on Contracting Out from Denmark and the United States', *Public Management Review*, Vol. 4, No. 1, 2002.
9. This refers to an agreement signed with commercial health providers in October 2001.
10. B. Griffith, 'Private Finance in Health Care—Why Not?', NHS Consultants' Association, 2000.
11. Allyson Pollock, David Price and Declan Gaffney, *The Only Game in Town? A Report on the Cumberland Infirmary*, Carlisle UNISON Northern Region, 1999; Allyson Pollock, Jean Shaoul, David Rowland and Stewart Player, *Practical Policies for the Redistribution of Wealth, Power and Opportunity: A Response to the IPPR Commission on Public Private Partnerships*, Health Policy & Health Services Research Unit, UCL, The Catalyst Trust, 2001.
12. Labour Party, 'Renewing the NHS: Labour's Agenda for a Healthier Britain', *International Journal of Health Services*, Vol. 26, No. 2, 1996, p. 280.
13. Centre for Public Services, *Private Finance Initiative and Public Private Partnerships: What Future for Public Services?*, <www.centre.public.org.uk>, 2000.
14. Sean Boyle and Anthony Harrison, *Investing in Health Buildings: Public–Private Partnerships*, The King's Fund, London, 2000, p. 24. Shortly after, the Health Secretary announced extensions of the PFI beyond the hospital sector into primary care and the social services, and the budget in 2002 pledged a further major growth of the PFI. Milburn, 2001, *op. cit.*; *Observer*, 21 April 2002.
15. *Guardian*, 19 September 2002.
16. *Guardian*, 1 October 2002.
17. R. Robinson and A. Dixon, *Completing the Course: Health to 2010*, Fabian Society, London, 2002.
18. These include the so-called golden rule that allows the government to borrow for investment but not current spending and the sustainable investment rule that requires the net ratio of public debt to national income to be below 40% of GDP over the economic cycle.
19. Jon Sussex, *The Economics of the Private Finance Initiative in the NHS: A Summary*, Office of Health Economics, London, 2001, <www.ohe.org/private_finance_initiative.htm>; P. Robinson, 'The Private Finance Initiative', *New Economy*, Vol. 7, No. 3, 2000, pp. 148–9.
20. *Guardian*, 3 October 2002. The report adds that 'privately, Treasury officials say the PFI projects could be financed conventionally without breaking [Brown's fiscal] rules'.
21. D. Heald and N. Geaughan, 'Accounting for the Private Finance Initiative' *Public Money and Management*, Vol. 17, No. 3, 1997, p. 227.
22. HM Treasury, *Public Private Partnerships: The Government's Approach*, <www.hm-treasury.gov.uk>, 2000.
23. Department of Health, *PFI Questions and Answers*, December 1999.
24. *Guardian*, 27 September 2002.
25. Boyle and Harrison, 2000, *op. cit.*, p. 37.
26. G. Allen, 'The Private Finance Initiative', *House of Commons Library Economic Policy and Statistics Section Research Paper* 01/117, December 2001, p. 32.
27. Royal College of Nursing, 'Memorandum to the Select Committee on Health', London, 2001.
28. Zosia Kmietowicz, 'News Roundup', *British Medical Journal*, 27 October 2001.
29. Boyle and Harrison, 2000, *op. cit.*, p. 39.
30. BBC Web site, 19 May 1999 (Peter Hawker); R. Smith, Editorial: 'PFI: Perfidious Financial Idiocy', *British Medical Journal*, Vol. 319, 1999, pp. 2–3; *New Statesman*, 7 December 2001 (Sir Peter Morris). 'Talk to most hospital managers or local government officers drawing up PFI deals', Polly Toynbee relates, 'and (off the record) they shrug with a grim despair. They had no choice, it was PFI or nothing: asked if it's

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good value, they tend to laugh drily and say they will be gone when the pigeons come home to roost.' *Guardian*, 27 September 2002.
31. Department of Health, 'For the Benefit of Patients: A Concordat with the Private and Voluntary Health Care Provider Sector', London, October 2001.
32. Ibid.; *Guardian*, 1 November 2000.
33. Labour Party Manifesto, 'Investing in Strong Communities', 2001.
34. *Guardian*, 25 May 2002.
35. Public Administration Select Committee Report, *The Public Service Ethos*, London, 2002, para. 4.
36. Quoted in ibid., para. 48. Raymond Plant, in his evidence to the Select Committee, defined ethos as 'a matter of the spirit of an organisation; it is to do with how it shares understanding, perhaps even with a shared tradition within an organisation, that kind of thing. It is ... a matter mainly of the habitual way people do things.' Lord Plant: House of Commons—Committee on Public Administration Minutes of Evidence, 8 November 2001.
37. Blair Tony, Speech to the British Venture Capitalist Association, July 1999.
38. Department of Health, *The NHS Plan*, <http://www.doh.gov.uk/nhsplan/nhsplan.pdf>, 2000.
39. HM Treasury, 2000, *op. cit*.
40. J. Clarke, S. Gewitz and E. McLaughlin, *New Managerialism, New Welfare*, London, 2000.
41. D. Gaffney, A. M. Pollock, D. Price and J. Shaoul, 'Planning the New NHS: Downsizing for the 21st Century', *British Medical Journal*, Vol. 319, 1999, pp. 179–84.
42. Boyle and Harrison, 2000, *op. cit*., p. 34.
43. *Guardian* 8 June 2002; *Guardian* 10 June 2002.
44. *Observer*, 29 September 2002.
45. Boyle and Harrison, 2000, *op. cit*., p. 351.
46. It is not part of the argument that public organizations are the unique repositories of the public service ethos, that public sector workers always display the ethos, or that private sector workers do not. It is important to avoid an idealized image of the NHS pre-Conservative reform. In addition to the survival of a significant private sector staffed mainly by NHS consultants, indifference towards service recipients and fellow employees, inefficient working practices and organizational rigidities could all be found. Notwithstanding these shortcomings, the pre-1984 NHS was based on 'high-trust' relationships which underpinned the public-sector ethos. Hunter, *op. cit*., p. 71.
47. As Dr Margaret Cook, a consultant haematologist, noted: by engaging in private practice consultants 'have done much to hinder the development of a universally fair health system ... As a body we can sometimes lose sight of the patient's perspective in concern for our own careers, prestige and specialities.' *Sunday Herald*, 13 January 2002.
48. Health Select Committee of the House of Commons Report 'The Consultants' Contract', 2000.
49. Health Select Committee of the House of Commons Report 'The Role of the Private Sector in the NHS', 2002.
50. Ibid., emphasis added. See also NHS Consultants' Association 'Memorandum to the Select Committee on Health', 2001. Though the Concordat has been in operation only for a short period, there are a few cases of consultants reducing their NHS workload or even setting up their own private firms. Discussion with consultants.
51. At present it appears that, for the most part, the commercial sector only possesses the appropriate skill mix or skill capacity to treat the less complex cases (interview with consultant ophthalmologist). Furthermore, at a conference on ophthalmology and the private sector attended by the present writer (and in later informal discussions) several consultants articulated reservations about the quality of care being afforded by commercial organizations that have negotiated or are in the process of negotiating Concordat contracts. See also NHS Consultants' Association, 2001, *op. cit*. Similarly, in its memorandum to the Health Select Committee, the Royal College of Nursing expressed concern that, as a result of the Concordat, 'the independent sector will take the clinically less demanding, leaving more acutely sick patients in the NHS' with adverse effects 'on the workload and morale of NHS staff'. Royal College of Nursing, 2001, *op. cit*.
52. NHS Consultants' Association, 2001, *op. cit*.

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53. Fred Hirsch, *Social Limits to Growth*, London, 1977, pp. 87, 89.
54. K. Walsh, *Public Services and Market Mechanisms: Competition, Contracting and the New Public Management*, Basingstoke, 1995, p. 198.
55. I. Hampshire-Monk, 'The Individualist Premise and Political Community', in Preston King (ed.), *Socialism and the Common Good*, London, 1996.
56. Paul Hoggett, 'New Modes of Control in the Public Service', *Public Administration*, Vol. 74, Spring 1996, p. 14.
57. H. A. Simon, 'Human Nature and Politics: The Dialogue of Psychology with Political Science', *American Political Science Review*, Vol. 79, 1985, pp. 293–304.
58. See Shaw Eric, 'What Matters is What Works: The Third Way and the Case of the Private Finance Initiative', in W. Leggett, S. Hale and L. Martell (eds), *The Third Way and Beyond: Criticisms, Futures and Alternatives*, Manchester, forthcoming 2004.
59. N. Deakin and K. Walsh, 'The Enabling State: The Role of Markets and Contracts', *Public Administration*, Vol. 74, Spring 1996, p. 33.
60. Gerry Stoker, 'Governance as Theory: Five Propositions', *International Social Science Journal*, Vol. 155, 1998, pp. 17, 19.
61. M. Temple, 'New Labour's Third Way: Pragmatism and Governance', *British Journal of Politics and International Relations*, Vol. 2, No. 3, 2000.
62. M. Rustin, 'The New Labour Ethic and the Spirit of Capitalism', *Soundings*, Vol. 14, Spring 2000, p. 122.
63. Patricia Hewitt, 'The Principled Society: Reforming Public Services', *Renewal*, Vol. 9, Nos 2 & 3, 2001.
64. Public employees, Tony Blair added, were 'more rooted in the concept that "if it's always been done this way, it must always be done this way" than any group of people that I've ever come across'. Blair, *op. cit*., 1999.
65. Speech by Andrew Smith, Chief Secretary to the Treasury, to the Partnerships UK conference, December 1999.
66. A. Whitehead, 'Cleaning Up the Dogma Doings: Labour and the Market', *Renewal*, Vol. 8, No. 4, Autumn 2000.
67. Julian Le Grand, UK-Policy: The Appropriate Role of the State, <ukpolicy@netnexus.org>, 1998.
68. A. Milburn (Chief Secretary to the Treasury), Speech at the Private Finance Initiative Transport conference, <http://www.hmtreasury.gov.uk/pub/html/speech/cft202999>, February 1999.
69. *Guardian*, 25 May 2002.
70. B. Parekh, Lords Hansard text, 24 October 2001 (211024–08).
71. David Marquand, 'The Fall of Civic Culture', *New Statesman*, 30 November 2000.
72. R. H. Tawney, *Equality*, London 1964 (1931).
73. Milburn speech, February 1999, *op. cit*.
74. Audit Commission, *PFI in Schools*, London, 2003, emphasis added.
75. Public Administration Select Committee Report, 2002, *op. cit*., para. 27.
76. Will Hutton, *Observer*, 10 January 1999.
77. Blair, *op. cit*., 2001.
78. HM Treasury, *Public Private Partnerships: The Government's Approach*, London, 2000.
79. Ibid.
80. A. Bevan, *In Place of Fear*, London, 1978 (1952), p. 98.
81. Marquand, 2000, *op. cit*.