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**Author(s):** Aldred, Rachel

**Article Title:** NHS Local Improvement Finance Trust and the new shape of neoliberal welfare

**Year of publication:** 2008

**Citation:** Aldred, R. (2008) 'NHS LIFT and the new shape of neoliberal welfare', Capital and Class 95, pp. 31-58

**Link to published version:**

[http://www.cseweb.org.uk/pdfs/CC95/C&C\\_Issue95\\_Art2.pdf](http://www.cseweb.org.uk/pdfs/CC95/C&C_Issue95_Art2.pdf)

**DOI:** (not stated)

**Publisher statement:**

<http://www.cseweb.org.uk/note.html>

# **NHS LIFT and the new shape of neoliberal welfare**

## **1. Introduction**

This paper discusses the NHS LIFT (Local Improvement Finance Trust) programme as an indicator of current trends in neoliberal welfare. LIFT, a new form of public-private partnership (PPP), offers an even more radical vision of service privatisation than the Private Finance Initiative (PFI). Promoters Partnerships for Health claim that LIFT is “a true partnership in every sense of the word”; a senior manager at the organisation told me in an interview that where PFI had created adversarial relationships between public and private sectors, LIFT gives corporations a seat at the “planning table”.

LIFT, like PPP more generally, forms part of the neoliberal welfare reconfigurations in the UK and elsewhere, creating new exclusions and new elites. Its birth and rapid growth are rooted in corporate power and the state-supported development and consolidation of new markets. When the UK National Health Service was created in 1948, elite consultants were seen as the major countervailing power, and generously compensated for the encroachment upon their business. Now, multinational companies - pharmaceutical firms, insurers, private medical providers, construction and service companies - tower over increasingly embattled publicly run health services and the clinicians operating within or even outside them. LIFT is a key organisational form allowing these companies unprecedented access to public service provision, and theorising LIFT helps us understand the changing face of neo-liberal welfare in more general terms.

This article discusses five major issues surrounding neo-liberal welfare as exemplified in the shift to LIFT-type models. These are:

1. The development of new elite networks and identities. This is important in allowing a shift away from a traditional ideology of civil service neutrality, and towards a discourse that celebrates “double-hatting”. The new discourse of leadership justifies a revolving door culture that no longer attempts to clearly demarcate representatives of the state and of capital.
2. Conflicts of interest between large and small capital (including GPs). LIFT represents a corporatisation of welfare, rather than simply a shift from the formally public sector to the formally private sector. GPs with their (however problematic) embeddedness within local health systems are replaced by multinational corporations organised into consortia. This creates proletarianising pressures upon clinicians.
3. The multiple meanings of “privatisation” (and the related terms commodification and marketisation). LIFT must be defined as representing both commodification and privatisation; however, LIFT companies led by large banks replace rather than create competitive markets. Public services are being remade in the image of – and interests of – financial institutions.

4. The status and meaning of “flexibility”, innovation, and risk-taking within these new power complexes. Service privatisation is often justified by equating private companies with these neoliberal virtues. However, LIFT’s model blocks local initiative and entrepreneurship, imposing instead a remote, bureaucratic, and inflexible outsourcing.
5. The changing but still troubled relationship between capitalist accumulation and the legitimation of the capitalist system. LIFT’s ineffective structures create renewed legitimation problems, and the system cannot easily be steered. Research into LIFT found high levels of private discontent among local NHS management.

The article concludes by linking these themes and by considering implications for activists challenging neo-liberal welfare. Additional themes not considered here include the topic of surveillance and welfare as punitive, as yet less prominent within LIFT but of deserved interest to critical analysts.

## **2. *The road to neoliberal welfare***

### **2.1 Theories of the welfare state**

What are the likely repercussions of a shift to neo-liberal forms of welfare? This section reviews some salient critical literature to discuss neo-liberal claims, aims, and practices. It builds on influential Marxist analysis of the welfare state (e.g. O’Connor 1976, Gough 1979, Offe 1984). While some of these models can be over-functionalist, they usefully move beyond a focus on the cost of welfare and examine *why* money is being spent and *where* it is going. This is particularly important for NHS “reform”, where the government claims that increased spending means any problems are the responsibility of inefficient public sector managers, greedy staff, or irresponsible service users.

O’Connor identified two sometimes conflicting objectives for welfare policy: establishing favourable conditions for capital accumulation and ensuring popular legitimation for the capitalist system. Under the first category would come projects and services that increase labour productivity or lower the social costs of reproduction. These functions are “indirectly productive” for capital (Gough 1979), providing goods and services that while not directly profitable allow private firms an increased rate of profit. The second category, ‘social expenses’ (or social control) is not productive for capital but helps to ideologically enrol workers into the system. The NHS, with its longstanding public support and traditional focus on curative medicine (primarily servicing the workforce, while those seen as non-productive received ‘Cinderella services’), can be seen to fulfil both. But settlements depend on struggle and are unstable. Even the first objective can have a tenuous existence: in the short run firms want lower taxes, but long-term competitiveness may depend on state services (Pfaller, Gough, and Therborn 1991).

State support for accumulation is direct as well as indirect, and this duality is increasingly salient – and problematic. As well as indirectly improving conditions for capitalist accumulation generally (providing road infrastructure, publicly organised education, etc.), traditional public procurement directly provided profits for individual firms. Even within UK

welfare state provision at its most “public”, many goods were provided by private companies (e.g. buildings, pharmaceuticals, roads, etc.) while related services were often provided publicly: this division is perhaps clearest for the NHS. As the post-war British economy was based on manufacturing, private service provision was then relatively small and weak. Public provision in these areas was not experienced as a major threat to capitalist interests. However, current developments in welfare encourage the extension of direct accumulation, as the service sector grows and its firms demand a share of public sector expenditure – the state as client rather than as competitor.

## **2.2 From Keynesianism to neoliberal welfare**

This pressure from the private sector has been part of a growing challenge to the welfare state since the end of the long boom (Ferguson et al 2002). Its legitimacy has been undermined by attacks from the right and the left, from critiques by user-led movements to the re-conceptualisation of public sector employees as ‘knaves’, not ‘knights’ (Le Grand 2003). Meanwhile, the welfare state has come under attack for *hampering* accumulation, rather than supporting it. Thatcher spoke of a dependency culture created by welfare benefits; New Labour valorises “entrepreneurialism” and portrays public sector staff as inefficient and unproductive. From the late 1970s onwards, writers of very different persuasions in the UK and other countries have concurred that the welfare state is in crisis.

For neo-liberals, welfare privatisation promises to solve problems of accumulation *and* legitimation. Breaking the power of the trade unions enabled – and was enabled by – the establishment of neo-liberal welfare. Outsourcing contributed to the decline in union membership in 1980s Britain, as a public sector culture that tolerated unionism was replaced by a private sector culture that saw it as blocking higher profits. The public sector itself changed, as the threat of outsourcing often secured concessions from labour (Whitfield 2001). Another way of breaking the welfare deadlock on terms favourable to capital was encouraging service users to see themselves as customers, atomising and individualising them (McGregor 2002) – although O’Connor (1986) points out that consumerism can be a source of (contradictory) resistance.

Justified by market rhetoric, the practice of neo-liberal welfare centrally involves the financialisation of service provision (Cutler 2001). Whether or not actual markets are created, or provision is shifted to a private sector provider, goods, services, staff, and service users are reconceptualised within a commodified discourse. For example, references to a “local health economy” may replace references to the NHS or public sector in documents about primary care provision (Aldred 2007). Leys (2003) outlines four conditions for financialisation: firstly, goods or services must be commodifiable (i.e. constructed as quantifiable and exchangeable); secondly, the public must be persuaded to want these as commodities; thirdly, the labour force must be transformed, and finally the state must absorb risk through direct subsidies. Thus neo-liberal welfare produces distinct strategies to aid accumulation (through further attacks on labour, state support for firms, and instituting or increasing individual charges for services or goods) and legitimation (justifying the changes by presenting commodified services as natural, such as

downgrading clinician-patient relationships and conceptualising primary health care as a series of discrete, countable, anonymous interventions).

Many critics (e.g. Pollock 2004, Edwards and Shaoul 2003) have argued convincingly that neo-liberal welfare should be seen as generating externalities, transferring rather than cutting costs. When companies attack trade unions, they take money from individual employees and from the public purse; for example, moving workers onto part-time shifts results in a lowered tax take and leaves employees dependent on means-tested benefits. While neo-liberals claim that privatisation creates or adds value, it has actually redistributed income from individuals and from the state (and sometimes from other capitalists) towards favoured firms. In the short term, although this has failed to remedy low growth rates, it has helped capital to increase its share of national income.

The UK government has embraced an overt shift in its role from arbitrating between companies to representing particular business interests as the national interest (Flynn 2000). Yet this aggravates a tension between welfare as directly productive, and as indirectly productive. While the former has always been a component of the welfare state, neo-liberal policies produce a dual privatisation movement (Ellison 2006), prioritising direct profit-making and shifting the costs associated with social reproduction onto individuals or their employers. This can cause conflicts between firms directly benefiting from welfare contracts, and firms feeling the effects of service withdrawal. For example, PFI deals often move hospitals and health centres out of town to greenfield sites, which are more difficult to access and may result in workers needing to take more time off for medical visits.

Moreover, this new accumulation regime may generate legitimisation crises if it is perceived as benefiting a group of firms at the expense of individuals or the “nation”. One potential resolution might be the creation of new “company towns”, where businesses embed themselves in their local area and produce localised services (Harvey 2001): this model seems to have informed the thinking behind LIFT (see below). Another response has been the development of complex models of privatisation and the promotion of welfare reform as generating “plurality” rather than “privatisation”, “partnership” rather than “profit” (Ling 2000). Additional legitimisation claims are based around the argument that privatisation enables innovation, flexibility, and risk-taking. In PFI-based privatisation models it is the “risk transfer” element that justifies their use, enabling initially more expensive schemes to appear cheaper.

### **2.3 The PFI model: design, build, finance, and operate**

Excepting Wales<sup>1</sup>, PFI is practically *the* route for public procurement of UK hospitals (and many other new buildings); its descendent LIFT is becoming the dominant method for new primary care developments in England. But PFI’s beginnings were unpromising. The then Conservative government created PFI in 1992, while Labour opposed it. Progress was slow and when Labour was elected in 1997 only a handful of projects were proceeding (Whitfield 2001). However, perhaps to signify its business-friendly credentials, the new government swiftly transformed PFI into the procurement route of choice for public sector capital projects.

PFI's novelty rests on its bundling of design, construction, and operational services within one long-term contract, financed by private borrowing repaid yearly over decades through a unitary service charge. At the end of the contract buildings will usually revert to the public sector, a concession to critics. Traditionally, public sector capital projects were built and designed by the private sector, and increasingly 'support services' are run by the private sector. However, PFI's impact is not merely due to the addition of private finance. It is creating a consolidated industry in which large private firms (financiers, construction companies, and service providers) collaborate in consortia, creating complex state-supported oligopolies (Pollock 2004).

These firms are gaining long-term control over the ownership of 'public' buildings (through share sales and debt transfer) and how these buildings are managed and run (through the award of sub-contracts). Instead of paying a one-off cost for an asset, the public sector enters into a long-term service contract, giving the asset owners a long-term government-backed cashflow. This is proving popular with pension funds and private equity vehicles specialising in the secondary market: once the asset has been built, the contract becomes extremely low risk. Over the remaining years of the contract, the owner may refinance bank debt, cut costs on maintenance and support services, and/or persuade the public sector to pay more than the originally agreed annual charge. None of these strategies is possible in traditional public procurement, or through short-term contracting for individual services.

PFI is complex, and public sector managers must accept responsibility for problems, while often lacking knowledge of the legal complexities. Special Purpose Vehicles (limited liability PFI consortia) are typically composed of a construction company, financial institutions, and a facilities maintenance company. The SPV contracts with the public body, sub-contracting work to other companies, often sister companies to consortium members. Open competition is limited to the involvement of usually around three (but sometimes fewer) consortia that submit bids at the start of the tendering process. Contestability is low, given the complex and networked relationships between a relatively small number of companies, which now comprise the market for public procurement. As far as the public body is concerned, any such competition or contestability would generally only occur at the beginning of the contract; if extra work arises relating to the assets it must usually be offered to the existing contractor.

PFI represents a political compromise, as initially the NHS's popularity prevented the privatisation of jobs such as nursing and doctoring. Thus PFI contracts exclude 'core' staff, who remain in the public sector. Definitions of 'core' and 'support' are flexible: in the NHS 'support workers' can include some clinical services, such as pathology. Generally, the 'core' has meant the most powerful professional group(s): teachers in PFI schools and doctors and nurses in PFI hospitals, as well as managers and administrative staff supporting them. As critics have charged, this has led to the degradation of 'support services' such as school meals provision, which are no longer seen as essential and can be 'sweated' alongside the rest of the PFI contract, in the industry's words (Halligan 2006).<sup>2</sup> However, the core/periphery distinction is unstable, and 'core' services are increasingly targeted.

## 2.4 LIFT: “Partnership” beyond PFI

NHS Local Improvement Finance Trust (LIFT) covers half of all English NHS Primary Care Trusts (PCTs)<sup>3</sup>. It is a development of the PFI model for primary care premises, and has already spawned a related model in the education sector, Building Schools for the Future. LIFT will mean that GP surgeries and health centres will shift from being largely owned by GPs and the NHS to corporate ownership: currently, three in five surgeries are owned by individual GPs, and one in five by the NHS. Like PFI, LIFT involves the private sector letting buildings and attached services to the public sector. LIFT is complex and its structure can only be sketched out here: for more information, please see my report for UNISON (2006).

Each of fifty-one LIFT localities will have a 20-year Strategic Partnering Agreement between a group of local NHS Trusts and a consortium known as a LIFT company (LIFTCo). The agreement includes an “exclusivity clause”, meaning that over the life of the agreement a local LIFTCo will have sole rights to develop any new primary care premises in its area. It will then lease out the buildings over 25 years to service providers, while providing some support services as per the PFI model. Importantly, while PFI involves a project company managing a project, LIFT will include “buildings we haven’t even thought of yet”, as one interviewee commented. A public sector representative sits on each LIFTCo board, and private sector personnel join with public sector managers on the Strategic Partnering Boards set up to plan local primary healthcare provision.

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

Data used here derive from research into LIFT at national and local levels. Following effective quantitative critiques of PFI (e.g. Pollock 1994), justification of welfare reform policies shifted onto a qualitative level. The National Audit Office’s report on LIFT (2005) eschewed calculating public sector comparators for talk of qualitative benefits of working in “partnership”. I decided to use critical ethnographic research to understand and analyse these claimed cultural changes. The approach drew on Marcus’s (1999) concept of the multi-site case study, in which detailed investigation may follow an object, rather than a group of people. For LIFT, this is appropriate, as each policy object creates relationships between people in numerous organisations, public and private, and complex financial transactions.

On beginning the investigation, most LIFT schemes were at an early stage, and the case study research focused upon one relatively advanced LIFT area (here this is referred to as “Wellston”). A range of strategies were

employed to increase validity. Firstly, I viewed the research as an embedded case study (Yin 2003), with inter-case comparisons between organisations in Wellston. I collected and analysed national level data to gain understanding of the programme as a whole. Secondly, I conducted more limited investigations into three “comparator areas”: one had been suggested as a “positive example” of success, one as a “negative example” of failure, and the third contained a prominent insider critic of LIFT.

In addition, triangulation was used at a methods level. The research involved over thirty observations of local and national meetings and events and a similar number of interviews with informants, from senior managers at Partnerships for Health (PfH), the agency leading the national programme to clinicians, local private sector personnel, and middle-level managers from Wellston’s four NHS Trusts. Relevant documents were analysed for content and discursive patterns, and LIFT’s local and national structures were studied. These strategies allowed me to be reasonably confident about the value of the patterns that I was identifying from my data. Moreover, the value of the data reaches beyond the particular policy area: I argue that the LIFT model represents a new stage in the neoliberal restructuring of welfare<sup>4</sup>.

### **3. Theorising LIFT**

#### **3.1 The new elites: bridging the public and private sectors**

LIFT has enabled and reinforced new elite networks, dominated by senior public and private sector executive managers. These dominated the national LIFT forums that I attended. Relatively few non-executive NHS Trust directors or clinicians attended, and even fewer patient representatives. Such structures bypass traditional ‘clinical governance’ that incorporates a layer of GPs and other professionals, instead involving representatives of large private corporations. The perceived independence of clinical judgement is under threat from this public-private elite. LIFT further sidelines traditionally marginalised patient organisations; in my main case study area these were unaware of its existence, and they did not attend the high-level Strategic Partnering Board meetings.

The new public-private elites are marginalising old conceptions of public sector duty and independence, replacing civil servants with “double-hatters” whose conflicts of interest are no longer regarded as embarrassing but as a source of pride (Aldred 2007a). Ironically, this is happening when WTO and EU market regulations are being brought in stressing “non-discrimination” between service providers. However, PPP models effectively outsource commissioning to private sector organisations, absolving those commissioning public services of the responsibility to follow public sector commissioning regulations (and other public sector regulations relating to Freedom of Information, etc.).

An infrastructure has developed to support the “PPP/PFI community”, with private meetings and conferences where senior public and private sector managers come together nationally and locally. This provides a practical basis for state elites to see the national interest as essentially identical to the PPP/PFI industry’s interests. For example, UK Auditor-General Sir John Bourn told the industry’s PPP Forum in 2003:



[W]e'll [i.e., the NAO] make our contribution to your success, and your success is the success of the community at large.

and

[T]he National Audit Office will be with you all, public sector and private sector, in making further success into this century of PFI and PPP.

Bourn argued that the role of the auditor has shifted: s/he should no longer evaluate whether policies meet stated government objectives. Instead, the auditor's "independence" lies in the ability to objectively improve and refine programmes, rather than assessing them. One should not expect the NAO to state that LIFT may conflict with government objectives to provide greater choice for patients, for example. Instead it will make recommendations to ensure that policies are "an even greater success".

Characteristically, the design, promotion, and management of LIFT as a national policy were entrusted not to the state itself, but to a part-privatised quango, Partnerships for Health<sup>5</sup>. The Chief Executives of Partnerships for Health and its then parent body Partnerships UK were exemplary double-hatters. One, a chartered engineer, comes from a construction industry and PFI background. The other was a senior financier working for multinational institutions on PPP projects in the UK. Part of their significance is the way that they have brought together major finance and construction firms, with the active support of government.

Like these two senior executives, many key players have little or no health sector experience, although others have worked in the NHS and/or the private health care industry. While PfH displays a private-sector orientation and promotes the benefits of 'co-operative working' and 'partnership' with the private sector, it is located within the Department of Health building. It could thus be seen to symbolise contemporary UK welfare governance: the state as not so much lean, but constructing complex quasi-private layers within itself. New bureaucratic layers may create obstacles and inefficiencies, but they can act to exclude outsiders, bind insiders together, and obstruct the scrutiny of government.

As Leys (2006) argues, elite networks have become both broader and narrower: narrowing the gap between "public" and "private", including more multinational players, but excluding professionals and lower-level elected representatives. Under LIFT, 'partnership' with private corporations replaces 'partnership' with GPs. In an earlier piece (Aldred 2007a), I argue that this creates "closed policy networks and broken chains of communication". Actors such as GPs and service users are excluded, rather than being co-opted as (respectively) businesspeople and consumers. The multiple identities (and financial interests) promoted by the double-hatters are, like large public procurement projects, effectively limited to the elite. Their rejection of professional knowledges for private sector mystique is epitomised in this comment by a financier working on Wellston LIFT:

I'm not sure what I have a background in really. I've been doing this job, obviously, I spend a lot of time with health people. Do I have a formal,

professional qualification in medicine and all that kind of stuff – absolutely no way, none whatsoever. I mean, my father was a GP (laughs) but that’s got nothing at all to do with it.

### **3.2 Centralising capital and proletarianising professionals**

Over the past twenty years of NHS reform the medical profession has been under increasing pressure, from the Griffiths report (recommending the introduction of general management) to the recent withdrawal of professional self-regulation. In primary care, most doctors are both professionals and petty capitalists, paid from the profits of their practice; this fitted within a broader structure that saw most GPs organised as “independent contractors” selling their services to the NHS. This stabilised the system for some time at the cost of long-term underinvestment (Pollock 2004); however the end of this period was heralded by the new GP contract. The contract seemed like an excellent deal for practitioners, offering a large pay rise and an end to responsibility for out-of-hours care. The double-edged sword is that GPs are losing the traditional basis for their particular professional status; the provision of personal, one-to-one care, day or night (Berger and Mohr 1967).

Trends towards larger primary care centres, including some run by private companies employing salaried GPs, will reduce GPs’ historically high levels of autonomy. New contracts prioritise meeting targets and an increasing proportion of practice incomes now come from these payments, which use financial incentives to direct GP activity rather than the more traditional capitation income. LIFT itself is part of a trend towards greater managerial control over GP labour by removing practice ownership from GPs. Like out-of-hours care, the latter has often been experienced as a burden by GPs, yet it provided them with a modality of control over their labour not available to other professionals.

In almost all LIFT areas, “private sector partners” are national or multinational corporations. In Wellston the banks had refused to engage one of the smaller building companies already known to the local NHS, and so a national company had been chosen. The opening up of GP services to large companies demonstrates the interests behind “the plurality agenda”, and the limits of market discourse. If the government merely favoured private ownership *per se*, the existing patchwork of small GP surgeries would surely seem ideal. Perhaps it would merely abolish catchment areas and so free up the market in GP services. However, the interests of large firms and particularly those within the PFI/PPP industry are the key to neo-liberal welfare reform. PFI and LIFT are both resulting in services being centralised and co-located, often in out-of-town sites. Whether this is more “accessible” is debatable, particularly for people without private transport. However, it suits large companies who do not want to deal with what a LIFTCo manager described to me as “itty-bitty contracts”.

Part of the justification for the new arrangements is a claim that previously the NHS was monolithic, and a “diversity of providers” will break down such bureaucratic “silos”. Academic commentators have accepted some of this conventional wisdom. The otherwise balanced literature review by Ferlie and McGovern (2003) characterises NHS governance as traditionally “bureaucratic”, despite the historic structure of general practitioner service

provision. This small business/professional model had drawbacks, but hardly represented classic bureaucracy. LIFT demonstrates the inadequacy of equating a “pre-reform” NHS with monolithic bureaucracy; as GPs interviewed pointed out, LIFT is arguably more top-down and bureaucratic than the often rather fragmented system that it is replacing (see further 3.4 below). One might suspect that GPs are losing out because while formally “private”, they are not corporate, generally working within a small business model governed by professional ideology or individual gain but not share price.

As befits an era where supermarket heads advise governments on health services, the LIFT surgery of the future is what the Department of Health calls a one-stop shop (a supermarketised concept, like the rebranding of libraries as “Idea Stores”). It will have around ten GPs and a range of “income-generating” services, from leisure centres to social services to retail units. This turns GPs into one of many service providers within a building they do not own or control.<sup>6</sup> While the marginalisation of staff and service users initially enables contracts to move forward relatively speedily, it creates longer-term problems and instabilities. In Wellston, most GPs were sceptical or oppositional. The one GP who had initially spoken out in favour of LIFT admitted to disillusionment. Instead of letting GPs act entrepreneurially and reap financial and status rewards, financialisation privileged the position and expertise held by financiers and managers:

Most of LIFT is quite high level finance discussion. That was done by the estates department, or people that they’d got in to do that. Way beyond my understanding.

While public sector professionals are officially urged to become “entrepreneurial”, the corporatisation of welfare discourages this. LIFT marks a shift away from GP owner-occupation towards tenancy; GPs are becoming more like employees rather than businesspeople. An initial plan to offer GPs shares in LIFT companies has not materialised; GPs in Wellston complained that LIFT company ownership of premises made it expensive and difficult for them to change and develop their services. Any building alterations, however, minor, had to go through the LIFT process, whereas previously GPs would have been able to obtain competing quotes from three local companies. GPs argued that this stifled their autonomy and control over service provision.

The problem is that things change all the time. A viable, thinking practice is going to keep changing. They have to have the fluidity to change quickly.

(GP representative)

Here, despite the claims to “entrepreneurialism” often made in pro-privatisation discourse, large corporations are replacing GPs, who after all are also small business people and thus more easily cast as entrepreneurs than big bureaucracies. The state is playing a key role in organising the centralisation of capital; under the aegis of successive Labour administrations it has created a “PPP industry” made up of major firms acting together in consortia. One aim of creating this industry is to increase managerial control over GPs, and this goal was clearly recognised by interviewees (Aldred 2007).

While GPs are unlikely to become fully proletarianised, the changes in their labour process means that they are becoming more like other professional employees, losing the clinical autonomy and control over premises that long set them apart from other professionals such as teachers.

### **3.3 Commodification: but where is the ‘market’ and the ‘competition’?**

Definitions of privatisation practices are contested. Depending on the audience, Britain’s New Labour government still sometimes wants to claim that it is not privatising; with LIFT, it uses the fact that many GP surgeries are already in private hands. But firstly, *in practice* LIFT is privatising NHS facilities: in the areas that I studied, initial schemes transfer NHS sites to private ownership. Secondly, the private/public divide is not purely legal, but should be understood socially and historically, involving formal or informal rights. In eighteenth century England, employers fought to ensure that ‘their’ cloth was seen as theirs and not something over which textile workers had customary rights (Linebaugh 2006). Traditional GP ownership may legally be “private”, but covenants often ensure that buildings can only be used for NHS services. Tied to the NHS through long-term partnerships, GPs (and their patients) see themselves as part of the NHS (Tudor Hart 2006). A shift to corporate ownership disembeds surgery ownership from its historical location, which has anchored it closely to the ‘public’ and the ‘public sector’.

In addition, the concept of privatisation should be used more broadly than just to describe a formal shift in ownership from the public to the private sector (c.f. Harvey 2003). The contractualisation of relationships between different organisational units within a range of public services, from the BBC to the NHS, helps to turn the services exchanged into commodities even if they are not sold on the open market. Privatised ways of operating become embedded within these organisations (Born 2005); organisational identities become ‘privatised’ – modelled on those existing (or thought to exist) in private firms. A “public sector director” sits on LIFT boards and is responsible to the public sector organisations *in their capacity as shareholders in LIFT*. S/he must prioritise the financial health of the LIFT company even if it conflicts with health care needs. This role is only public if public sector organisations are seen as corporations that happen to have a state shareholding.

Does the LIFT model also represent the commodification of welfare? I would argue that it does, albeit not directly. With GPs as independent contractors, and practices individually responsible for their own premises, the commodification of surgeries was limited. This certainly had drawbacks; many GPs failed to invest in their premises or to upgrade and modernise them (Tudor Hart 2006). However, neither did they try to maximise revenue from premises by opening them up to other ‘income streams’. Shifting premises ownership to large financial institutions is likely to do exactly this, and in Wellston I witnessed attempts to find such additional revenue generating opportunities. The more successful LIFT schemes seem to be doing this with greater efficiency and ruthlessness, allocating space in advance and securing long-term rental commitments (e.g. from supermarkets). Of course, while this may benefit the LIFT companies involved, it may not benefit the local NHS Trusts<sup>7</sup> or the local population.

While I would describe LIFT as representing privatisation and commodification for reasons outlined above, it is not in any simple sense a “market solution”. It absorbs large amounts of public resources from the NHS locally and nationally, in terms of staff time, additional monetary costs, and so on. Market elements are also limited by the ‘exclusivity clause’ which has already prevented GPs raising finance privately (Crump 2006). PPP represents a shift from short-term to long-term contracting, and it is the former that represents a purer market relationship between parties (Flynn 1994). Indeed, corporations do not necessarily want “more market” applied to themselves, although market rhetoric often forms part of the ideological justification for privatisation. Private health companies successfully lobbied the government to ensure that they were granted higher tariff rates than the NHS *and* block contracts regardless of the volume of actual operations carried out (UNISON 2005), neither of which suggests a commitment to the rigours of market competition.

By contrast, LIFT *does* encourage competition between *public sector* bodies. Usually a LIFT company is tied to several NHS primary care trusts, each struggling to make their own projects attractive to the LIFT company. Under PPP, corporations benefit from long-term contracts, while the public sector experiences insecurity and competition. Given this clash with the “market” rhetoric justifying the process, no wonder many public sector interviewees claimed that they were the true “entrepreneurial innovators”. PPP represents monopoly for the PPP industry and markets only for those less privileged.

David Harvey (2005) argues that neoliberalism does not attempt to impose a market utopia, but is instead about the restoration of class power. Of course, the capitalist class is not homogenous and, as I have suggested, small capital is losing out under PPP. Financial capital is dominant under LIFT structures, with banks ultimately making decisions on whether schemes proceed. While construction and services companies benefit from the scheme, they are not in charge of it to the same extent.

### **3.4 Stifling innovation and risk-taking: the virtual bureaucracy**

Data portraying PPPs in practice injects caution into claims that privatisation releases innovation and flexibility stifled by public sector bureaucracies. This argument has become accepted wisdom in elite policy circles. In 2001 (when plans for LIFT were being finalised) a Department of Health official told the Daily Telegraph that then health minister and Blairite Alan Milburn “wants to get rid of the NHS monolith which suppresses enterprise and innovation within the NHS” (Cracknell 2001). Former Chief Executive of Partnerships for Health David Goldstone told the Contract Journal (2003) that LIFT the model was “a hybrid that took the best from traditional PFIs and PPPs and the existing primary care model”. LIFT was “something that would be responsive to the changing clinical requirements and needs... LIFT allows this flexibility because of the level of partnership between the public and private sector.”

In the case study the key local representative of this ideology was a financier. He argued that corporate involvement in primary health care

provision would bring “enthusiasm” and “drive” that could break down old bureaucratic boundaries, complaining that “most people in the public sector, the way they do it, they’re used to separate organisations, aren’t they?... And all of those organisations tend to act in a very independent way, which actually is a bit mad.” Similarly, a National Audit Office auditor explained the logic behind their positive report on LIFT. He said that private sector investors believed LIFT moved on from PFI in allowing the private sector more freedom to create “a much more flexible business model”.

Yet private sector practices developed to manage customer demand, control labour, and rationalise production can hamper speed and innovation. In Wellston, a call centre based outside the region was replacing dedicated, on-site maintenance staff. To access the repairs service, a member of staff now had to contact the building manager, who would contact the call centre, which would contact an engineer. A process involving one step (contacting a PCT maintenance engineer) had been replaced by three steps. This more complex procedure may deter staff from calling on the maintenance service, and creates opportunities for requests to become lost in the system.

More specifically, by giving a private contractor long-term monopoly pricing power, LIFT creates substantial blocks to flexibility of service provision, (UNISON 2006). As GPs commented, the monopoly stops staff from developing and realising new ideas. Only a LIFT company can sanction and arrange even minor alterations, so Wellston GPs in LIFT buildings were not allowed to pin up patient artwork. They had to call in the LIFT company (which would delegate to its subcontractors) to put up noticeboards or install sockets, jobs that might previously have been done for free by clinicians with DIY skills or that could have been offered to local craftspeople. Not only is this likely to be expensive (as a LIFT GP testified to the House of Commons Select Committee on Public Accounts), the process obstructs staff who have ideas for changes or improvements.

Moreover, the financial criteria used to plan additional services results in new ideas falling by the wayside. In LIFT buildings non-NHS areas are rented separately by the LIFT company as income-generating “retail units”. Wellston’s NHS managers had wanted a “community café” within their first LIFT centre, influenced by the groundbreaking success of a local healthy living centre. However, in accordance with LIFT’s prioritisation of profitability, the LIFT company had tendered the space commercially. Due to the high rents sought, the space proved unviable for commercial and non-profit café operators, so it remained empty while public and private sector managers tried (fruitlessly, during the fieldwork period) to find an acceptable compromise. This is an instance of a contradiction that I analyse elsewhere in more detail (Aldred 2007b): privatised structures fail to enable the privatised (e.g. “social entrepreneurial”) subjectivities that might embed them in self-supporting local social networks (c.f. Polanyi 2002).

Indeed, LIFT rents have marginalised the place of community and voluntary sector organisations within the new buildings, despite rhetoric about community involvement and “community ownership”. Such organisations cannot survive if treated as “income generators”. Rather than producing networks and synergies, LIFT disembods organisations from existing networks, and risks leaving privatised “local health economies” adrift in a sea

of commodified relationships. A shareholding logic relentlessly financialises services, downgrading outcomes that cannot be costed and charged.

This has led to small pharmacies losing out, this criticism even surfacing in the overwhelmingly positive National Audit Office (2005) report on LIFT. Documentation surrounding LIFT refers to “chain pharmacies” and there are no guidelines to ensure the retention of community pharmacies in new buildings (Aldred 2007). Wellston’s first LIFT building contains a community pharmacy, but only as a temporary concession after extended wrangling. Wellston’s local pharmacy representative criticised corporate pharmacies for only being concerned with profit:

They see their money. They’re vertically integrated. They pay less for the drugs which they’re dispensing, they can get a big discount. So they’re making more profit. And that’s really what they want to be doing.

Initially, LIFT companies were supposed to lease space directly to GPs on a short to medium term basis, allowing the NHS to benefit from “more flexible” relationships with professionals (PWC 2001). However, the private sector backed away from the risk of units remaining unlet, and so now LIFT companies lease to NHS organisations for 25 years, which then sub-let to GPs. This shields the private sector from risk, but exposes the NHS and creates additional contractual layers. Even financial flexibility seems limited; the financiers involved in the scheme have not created the variety of financing options originally envisaged by Partnerships for Health. Instead, the original PFI-based model remains the only choice.

The LIFT structure can be characterised as creating “virtual bureaucracies” (such as shell sub-companies and boards that rarely meet), rigid, and risk-averse (Aldred 2007). The shift from GP to LIFTCo ownership of premises is a shift from rooted to placeless capital, as well as a shift from small to large capital (see section 3.2 above). LIFTCo structures have been designed so that shares, and other financial instruments, can be sold on secondary markets through a plethora of holding companies (FundCos, which own individual centres).

In Wellston and in national LIFT forums, interviewees spoke of LIFTCo as “virtual” or “shell”, and its associated Strategic Partnering Board structures as “not really existing”. Wellstone’s local public sector managers found they had to act for LIFTCo, which seemed financially but not socially “real”. In two comparator areas, NHS managers agreed that they had had to largely control the LIFT process themselves; it had not become self-sustaining. Only in the other area, where open resistance had emerged, did the LIFT company seem to exist independently. In opposing it protestors had helped to construct something tangible that could be opposed. By contrast, in other areas there was little organised opposition and LIFTCo remained nebulous. One Wellston GP said frustratedly, “I just don’t know who they are”. But this failure paradoxically helped LIFT: it seemed hard to oppose something so slippery.

### **3.5 Problems of effectiveness and legitimacy**

In Wellston, it soon became apparent that LIFT was not working smoothly; in two of the three boroughs involved, it had reached the level of a

crisis of effectiveness. This produced an internal crisis of legitimacy among local NHS managers who, in general, did not seem ideologically opposed to NHS privatisation. Most had become disillusioned at LIFT's failure to live up to the extravagant promises of pro-privatisation discourses. However, they contained their frustrations within the local NHS and the walls of board meetings. While problems remained unspoken in public forums, an impasse had been reached; most of Wellston's NHS had few concrete achievements to show for its money, several years into the local LIFT programme.

This was not how it was meant to be. LIFT's planners seemed genuinely to believe that radically deepening private sector control over welfare would solve the problems already experienced with PFI. One key part of this was the idea that LIFT would make NHS managers think more "entrepreneurially" and see themselves as part of "their" LIFT company. Unlike PFI, LIFT creates a public sector shareholding; 20% of the local LIFT company's shares are held by local NHS organisations, which nominate a public sector representative to sit on the LIFT company board. Thus the LIFT structure has been designed not only to bring the private sector into NHS service planning, but also to embed shareholding logic within NHS managers' decision-making.

However, principles of "partnership" and "entrepreneurialism" herald renewed conflicts between accumulation and legitimacy. LIFT contracts place their holders in an extraordinarily favourable position. They do not merely concern one building or group of buildings, but give LIFT companies exclusive rights to develop *any* new primary care buildings in their area over the next twenty years. The model creates a new high-level Strategic Partnering Board to plan future service organisations in each LIFT area, dominated by senior private and public sector managers but excluding clinicians and patient representatives.<sup>8</sup> The planners believed that this top-down structure would allow projects to proceed without delay; for example, they mistakenly thought that involving local authorities in LIFT would make the planning process a mere formality (Aldred 2007a).

In national LIFT seminars, participants repeatedly referred to problems that had occurred when local people had objected to projects at the planning stage. As a LIFT-supporting consultant based in Wellston told me, the exclusion of local communities from LIFT structures was a false economy which often meant that

a local residents group would put in a planning objection and that would have a financial impact on your scheme. It may delay it for eighteen months and nothing will happen at all. If you don't get local goodwill then you're not going to be able to develop the scheme perhaps at all.

In Wellston, LIFT's legitimacy had been dented among the NHS managers who were supposed to identify themselves with it. Most expressed concern over the slow pace of developments, and the additional work and costs involved. For example, NHS staff had been seconded to LIFT, although the NHS continued to pay at least some of their salaries, and one Trust was providing LIFT with apparently free office accommodation. Only one local NHS manager interviewed (out of ten) did not criticise LIFT during the



interview. This was the chief executive of the “lead PCT”, who had initially served on the LIFT company board.

Structures had been designed by high-level elites, without any input from the people who would have to implement and manage them (i.e., the managers), let alone from staff and service users. No one in Wellston seemed to feel that the governing Strategic Partnering Board was doing its job. A consortium of large companies based outside the area, the LIFT company seemed to lack the local knowledge necessary to find sites for development. Indeed, one GP surgery had been waiting three years for the LIFT company to identify a suitable new site.

This was corroborated by the comparator area in which LIFT appeared to be running most smoothly, although still not entirely without problems. A non-executive director there, generally critical of the LIFT concept from the viewpoint of a small businessman, felt his area’s choice of a local firm was crucial. He said:

We’ve built up connections. And they’re nice people, and they genuinely want to do it in the right way for us, and to enhance their own reputation locally in doing that. But there are some LIFT companies elsewhere in the country where that doesn’t apply at all. We’re very grateful we haven’t got one of the national names that as you’re recording this I won’t mention.

However, his LIFT area was extremely unusual in having chosen a local firm, and he claimed that national policy-makers discouraged this, preferring local managers to choose “national names” (see 3.2 above). This reliance on large firms strained relationships with local “social enterprises” and small businesses in Wellston. Representatives of these organisations felt that they had not been included in the LIFT model, and that short-term financial gain was being prioritised over community regeneration. While LIFT enshrines the “local” in its title, local involvement is limited. Instead, as Harvey (2001:353) suggests, risk absorption is localised, as private capital and the national state attempt to devolve responsibility for service failure.

Thus while LIFT had been designed to foreground accumulation, and make the NHS and its local managers more geared to profitability, this strategy had run into problems. It generated legitimisation problems owing to the policy’s perceived secrecy and impermeability to outsiders, with even local NHS managers tending to see themselves as outsiders. The process became bogged down and led to further delays and disengagement by all sides. To NHS managers the private sector seemed less interested in entrepreneurialising the “local health economy” than in securing long-term guaranteed revenue streams.

Thus, steering problems (Habermas 1976) are likely to intensify. The long-term, complex contracts being negotiated by public authorities create unforeseen difficulties in responding to new demands from firms, service users, employees, and government. GPs and NHS managers will need to rely on complex procedures that they do not control, governed by contractual documentation and a powerful monopoly supplier. So while the public sector is exhorted to marketise itself, and services are re-conceptualised as commodities, a new monolith is being created, supported by complex and exclusive elite networks.

#### **4. Resisting LIFT**

Yet popular legitimacy for this regime is far from assured. Rather than providing the promised “personalised services”, large companies and consortia seem more likely to favour simplicity and standardisation, guaranteeing them a smooth and reliable income stream. This squeezes out small companies, voluntary initiatives, and professionals, frustrating their hopes of autonomy and/or profit, threatening to deny privatisation initiatives the social support that they need to function. The different rules and privileges applying to favoured “corporate partners” create a particular image problem for the neo-liberal welfare state, and one which is at odds with entrepreneurial rhetoric.

However, resistance is often patchy, localised, and defensive. In Wellston, local trade unionists felt exhausted by constant pressure from local management and government policies. One branch won a temporary victory: faced with the imminent privatisation of a primary care trust maintenance department, this local union had produced a dossier about the company to which employees would be outsourced. The firm has been the subject of allegations of racism in its management of prisons and detention centres. The primary care trust backed down faced with the threat of negative publicity; but as LIFT centres are built, maintenance will shift to the firm and employees will eventually be transferred to it piecemeal.

There are tensions and ambiguities within professional attitudes to LIFT. Some Wellston GPs categorised themselves as politically progressive, and thus were critical of the running of GP surgeries as small businesses (even though they might be doing this themselves). These GPs tended to support the development of “one-stop shops” partly *because of* their perceived deprofessionalising effect. At the same time because GPs are organised as small businesses, they lacked the resources to effectively counter LIFT and were left fighting a rearguard action surgery-by-surgery. Indeed during the fieldwork year LIFT was not discussed as an agenda item at the national conference of Local Medical Committees. The left-wing Medical Practitioners’ Union (part of Amicus) did not take a clear position on LIFT; neither did the mainstream British Medical Association. While GPs and pharmacists are being squeezed out by LIFT’s corporatisation of welfare, their position tends to prevent them from taking a clear lead on resistance.

The complexity of PPPs such as LIFT, and their often slow progress, means that explaining the issues in clear, simple language is vital, as people frequently feel confused and disempowered. However, the positive side is the potential for trade unions and service users to propose clear alternatives, in alliance with professionals, community organisations, and small businesses. Many of the latter are being excluded by the corporate re-alignment of welfare and so support (or be persuaded to support) principles of “public service” constructed in opposition to corporate profit. There is particularly strong potential for resistance to NHS reforms. Many service users believe that the NHS exemplifies an alternative “gift economy”, expressing public-ness as opposed to profit (Tudor Hart 2006). This is double-sided: as Doyal with Pennell (1994(1979)) argue, the belief that the NHS exists in a world of its own has silenced critique of ways that it has reproduced dominant value

systems. However, as the NHS is perceived to move ever further from an 'NHS ideal', critique in the name of this ideal may represent a potent source of resistance.

Research into PFI and LIFT has indicated contradictions inherent to this new ordering of welfare. PPP is expensive, putting increasing strain on the public purse. Far from acting as a seamless network of customers and entrepreneurs, PPPs often have to be heavily steered from the top and this is certainly true in LIFT's case. Researchers can usefully make this visible, as well as the existence and actions of the often hidden "double-hatters". This can demystify, expose, and critique fissures between the market discourse justifying the policy and the experience of high costs, bureaucracy and corporate collusion. Otherwise, future neoliberal welfare is likely to mean a greater concentration of finance-led corporate power in alliance with the state, and the aggravation of systemic crises in service provision, which are likely to be blamed upon their victims. PPP scarcely represents a new stable settlement in which free trade achieves unproblematic hegemony, but rather a constant battle for power between capitals, labour forces and users (c.f. Peck and Tickell 1997).

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<sup>1</sup> Although PFI projects dominate other sectors in Wales, the Welsh Assembly has backed away from PFI hospitals while using PFI for smaller health-related schemes.

<sup>2</sup> In contrast, the Welsh Assembly has re-defined the clinical team to include support staff.

<sup>3</sup> In the NHS, primary care is now commissioned (and to some extent provided) by NHS primary care trusts, here sometimes referred to simply as primary care trusts or trusts.

<sup>4</sup> For further detail on methodology please see Aldred (2007).

<sup>5</sup> In September 2006 it was reported that the Department of Health would buy back Partnerships UK's 50% share in Partnerships for Health. This has since happened.

<sup>6</sup> This may go further; particularly as fourth wave LIFT schemes explicitly include clinical services: GP partnerships may be replaced by private companies employing salaried doctors.

<sup>7</sup> While NHS Trusts are indeed minority shareholders in LIFT companies, LIFT is designed so that rents flow to holding companies within the LIFT structure, rather than the LIFT company itself. Indeed, many local managers interviewed saw little benefit from this shareholding.

<sup>8</sup> By contrast, existing Primary Care Trust structures pay at least lip service to the principle of "clinical governance", and include patient representatives.