

What do we do when the public services market fails?

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8/15/2014

What happens when outsourced contractors are no longer able or willing to continue with the provision of public services? [Bob Hudson](#) explores the downsides of outsourcing public services and finds the proposals currently in train to address 'market failure' in both health and social care to be lacking. He goes on to explore alternative approaches and writes that public services should be seen as something more than a contract put out to the market to secure 'value for money'.



Public services are being outsourced across the world. [Over the last year](#) alone the annual contract value for outsourcing across Europe, the Middle East and Africa has increased by 29 per cent. In 2011, David Cameron declared that he wanted to '[release the grip of state control](#)' on public services. This is one promise he has definitely kept – the amount spent on outsourcing public services in the UK has doubled to £88 billion since 2010. Overall the British outsourcing market is the second largest in the world outside of the USA.

Health and social care represent two interesting illustrations of this trend – social care has been [effectively privatised](#) for many years and now there is evidence that the NHS is beginning to [go the same way](#) in the wake of the 2012 NHS and Social Care Act. All of this creates a new policy dilemma: what happens when these outsourced contractors are no longer able or willing to continue with provision?

The [collapse of Southern Cross care homes](#) in 2011 – a large provider responsible for 31,000 older people mostly concentrated in one part of the country – brought the issue into stark relief. It quickly became clear that neither the local authorities nor the key national agencies had any contingency plans; indeed nobody even had any formal powers to compel action. Not the least of the problems here was the remote ownership of the company – the interests of offshore private companies had come face-to-face with the need for service continuity for highly vulnerable people in a new and politically explosive manner.

Proposals are now in train to address 'market failure' in both health and social care. There are two strands: a 'fit and proper person test' to be applied to directors and the seeking of provider assurances of financial stability. But are they up to the task? The Care Quality Commission (CQC) is [currently consulting](#) on the fit and proper person test which rests on the assumption that at least some of the problems of market failure arise from the capricious behaviour of the directors of providing organisations. This, it is reckoned, can be countered by an assessment of their character – honesty, integrity, competence and capability. CQC refers to this test as 'a significant restriction' but the impact is likely to be limited, with even CQC itself estimating that only around seven directors a year will be caught in the net.

Potentially more significant is the second proposal; to assess the extent to which a provider might be in such serious financial difficulty that there is a significant prospect of service cessation. Confusingly there are different routes for health and social care in this respect. In the case of the NHS the local clinical commissioning group (CCG) has to identify services for which there is 'no alternative provider' and designate these as 'Commissioner Requested Services' (CRS). In turn the healthcare market regulator, Monitor, will then oblige the CRS provider to send information regarding their financial stability. CCGs have a relaxed timetable – until April 2016 – to complete this review, and it is far from clear that Monitor will have the capacity or inclination to impose significant restrictive conditions on business activities.

The task of undertaking a similar role in social care has been given to CQC rather than Monitor. Here the law will take effect from April 2015, and is expected to involve overseeing the finances of around 50-60 care providers that would be difficult to replace were they to go out of business. The [Department of Health consultation](#) on this role did not suggest a tough approach to be in the offing, rather it was said to be a 'light touch approach', would be 'mindful

of the sensitivities' and respectful of 'the commercial sensitivity'. This will do little to worry remote ownership by creditors, private equity firms, property investors, bondholders, banks, shareholders and landlords.

What are the alternatives? One option is to 'shape' the market. This model goes beyond the notion that the role of the state is to 'fix' or somehow forestall market failure; rather it could use outsourcing as an opportunity to help 'transform' services and support. One variant here is that promoted by [Mariana Mazzucato](#) with her proposal for 'mission-oriented' public investments. Her argument is that public sector agencies have in the past led the way in this respect, investing along the entire innovation chain and defining new high-risk directions such as the internet, GPS and touch-screen display. The task of the state here is to determine the direction of change by 'transforming landscapes and creating and shaping markets'.

In relation to health and social care there is indeed much talk of the need for 'transformation', especially around a shift in focus from hospital care to community-based care, and there are abundant 'tool kits' on how to undertake the task. However there seems to be no strategy to harness the outsourcing of public services to any such strategic direction; rather, the end product is simply viewed as market diversification and the extension of 'choice'. Indeed, there is some doubt as to whether the NHS has any 'system leadership' whatsoever following the implementation of the new 'architecture' set up by the 2012 Act.

A further difficulty is that outsourcing tends to rid governments of the knowledge, capacities and capabilities that are necessary for managing change; the NHS and social care sectors have both been stripped of much of their management capacity in the name of 'reducing bureaucracy'. To undertake effective 'market-shaping' the state would therefore need to be revitalised so that it has the 'intelligence' or policy capacity to 'think big and formulate bold policies' – to 'transform'. This stands in direct contradiction to neoliberal demands for the state to 'get out of the way' of innovation.

In England the shadow health secretary Andy Burnham has pledged a different approach. He argues for taking the market out of the NHS and reinstating the NHS as 'preferred provider'. This will be no easy task given the existing scale of outsourcing and the remit of competition law, but in the meantime there are some 'procurement tests' that could be introduced:

- **A Transparency Test** could stipulate that where a public body has a legal contract with a private provider that contract must ensure full openness and transparency with no 'commercial confidentiality' outside of the procurement process. All providers should be made subject to local political scrutiny and to the Freedom of Information Act.
- **A Taxation Test** could require private companies in receipt of public services contracts to be subject to UK taxation law – Southern Cross was noticeably in the hands of offshore funds. Some of the biggest private providers of health and social care services in the UK such as Spire Healthcare, Care UK, Circle Health and the private equity firm, Terra Firma, have set up corporate structures that allow the avoidance of tax on millions of pounds of profits by making use of corporate entities overseas.
- **A Workforce Test** might have several components: a requirement to comply with minimum standards on workforce terms and conditions, training and development; a right to trade union recognition and collective bargaining; and a right to democracy in the workplace such as an easier 'trigger mechanism' for the right to request information and consultation.

But perhaps the most vital health and care debate is about what the popular philosopher Michael Sandel has termed [the 'moral limits' of markets](#). In this context public services like health and social care are viewed as the manifestation of communal solidarity, expressing a sense of moral obligation that citizens feel for each other. They are something more than a contract put out to the market to secure 'value for money'. The state is the vehicle for negotiating these obligations with citizens, for developing strategic thinking, coordinating inputs and serving as the ultimate source of legitimacy. This is the debate we need to be having, rising above dry and technical consultations on 'service continuity' and 'commissioner requested services' to think about what sort of society we want to live in.

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