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# **DOES THE UK LOCAL FINANCE IMPROVEMENT TRUST (LIFT) INITIATIVE IMPROVE RISK MANAGEMENT IN PUBLIC-PRIVATE PROCUREMENT?**

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## **ABSTRACT**

The UK government introduced the Private Finance Initiative (PFI) and, latterly, the Local Improvement Finance Trust (LIFT) in an attempt to improve public service provision. As a variant of PFI, LIFT seeks to create a framework for the effective provision of primary care facilities. Like conventional PFI procurement, LIFT projects involve long-term contracts, complex multi-party interactions and thus create various risks to public sector clients. This paper investigates the advantages and disadvantages of LIFT with a focus on how this approach facilitates or impedes risk management from the public sector client perspective. Our paper concludes that LIFT has a potential for creating additional problems, including the further reduction of public sector control, conflicts of interest, the inappropriate use of enabling funds, and higher than market rental costs affecting the uptake of space in the buildings by local health care providers. However, there is also evidence that LIFT has facilitated new investment and that Primary Care Trusts (PCTs) have themselves started addressing some of the weaknesses of this procurement format through the bundling of projects and other forms of regional co-operation.

## **INTRODUCTION**

In the early 1990's, the UK government sought to address inefficiencies it believed existed in the National Health Service (NHS). This involved the introduction of hospital trusts and the quasi-market for hospital-based health care to increase the cost-effectiveness of tertiary health care delivery and the introduction of GP Fund-Holders (GPFHs), making them the gatekeepers of funding for their patients and ensuring that funding followed service provision. Additionally there was a belief infrastructure procurement within the NHS procurement would benefit from attracting private sector funding and expertise previously

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unavailable to the sector. Since the government struggled to find adequate funding for basic maintenance, “let alone large scale investment without infringing Treasury limits on the PSBR and financial markets’ expectations regarding the long term sustainability of government expenditures” (Clark and Root, 1999), PFI was seen as a way of providing desperately needed upgrades (Clark and Root, 1999; Spackman, 2002). Following the introduction of the Public Finance Initiative (PFI) in 1992, by November 1994 it had become mandatory that all capital projects in the public sector requiring Treasury approval should explore the use of private finance options (Private Finance Panel, 1995) unless it was absurd or unrealistic to do so (Private Finance Panel, 1996; Akintoye et al, 2003). Whilst strongly criticised by the opposition at the time, PFI in various guises eventually became the lynchpin for capital estates reform for the subsequent labour governments and facilitated an increased commitment to the “buy now, pay later” approach which characterises much of the development and management of NHS estates (Clark and Root, 1999).

Among PFI supporters there was an expectation that new approach would attract private sector funds, resources, management skills, expertise and innovation to the provision of public sector infrastructure (Mustafa, 1999). It was also hoped that PFI would prevent many of the issues prevalent in public sector managed capital projects, including over-spend, delays, poor design, high operational and maintenance costs and low residual values (Forshaw, 1999) while introducing more commercial discipline and encouraging value for money (Birmie, 1999).

Whilst the government hoped that PFI would see private sector investment in the public sector increase significantly, in reality this failed to be the case (Clark and Root, 1999). Up until the mid 1990s, PFI failed to produce the levels of investment expected when it was announced, with targets for PFI investment being on average 50 per cent less than planned (Daily Telegraph, 1995). This was in part due to a feeling among public sector clients that they would be overwhelmed by this process, as well as due to reluctance by major private sector players to engage in the process (Asenova and Beck, 2003).

From a risk-management perspective, the implementation of the PFI process brought to light a number of issues which affected the uptake and effectiveness of PFI in the provision of public-sector services. Each of these is reviewed below.

### **Poor Risk Management (PFI)**

Whilst PFI was “not originally devised as policy for managing risk”, as Froud (2003) identifies, “risk has emerged as the key feature that legitimates the shift in public services management”. Initial guidance on PFI procurement suggested that that not all risks associated with a PFI project should automatically be transferred to the private sector. Rather, appropriate risks should be transferred to the private sector (Lonsdale, 2005) if they were better placed to handle them (Treasury Taskforce, 1997) to ensure “optimal allocation which is assumed to maximise value for money” (Froud, 2003). Since proposed PFI projects often failed to meet Value for Money criteria as embodied in the Public Sector Comparator, the quantification of risks transferred to the private sector often tipped the balance in favour of public-private finance over traditional delivery methods (Pollock, 2002). This, in turn, has led to widespread criticism of the PFI process on the grounds of inappropriate risk transfer (Clark and Root, 1999). Froud (2003), for instance, argued that, because of its size, the State is better

placed to manage risk, while Gaffney (1999) suggested that risk transfer was unlikely to occur in reality as private contractors would seek to protect their income from uncertainty whenever possible.

Whilst it was apparent early on that it was not always possible to specify the precise nature and distribution of risk (Clark and Root, 1999), it would seem that the public sector had particular difficulty understanding risk assessment and management. This was particularly true with regard to risks associated specifically with PFIs, with the public sector even struggling to find consultants who could help them with this process (Private Finance Panel, 1995; Akintoye et al, 2003). In a Treasury commissioned report it was found that “in over two thirds of the business cases for hospital PFI schemes the risk could not be identified. In other cases risk transfer was largely attributed to construction cost risks, which would be dealt with by penalty clauses under traditional procurement contracts” (Pollock et al, 2002).

In 1997, the Treasury Task Force identified seven groups of risk: “design and construction; commissioning and operating; demand (or volume/usage); residual value; technology and obsolescence; regulation (including taxation and planning permission); and project financing”. The Audit Commission (1998) later provided examples of generic risk categories associated with a serviced building, including such factors as “delays in planning permission, changes in interest and tax rates, higher than expected maintenance and costs of meeting new statutory requirements” and the risk that “essential public services cease to be available”. Given the breadth of these potential risks, it is easy to understand the scale of the learning curve faced by the public sector which had limited, if any, experience in these areas.

Lonsdale (2005) notes that uncertainty is “likely to be a considerable problem in complex contractual situations, especially when supply involves an innovation or constitutes a new venture”. This would certainly seem to describe the context of PFI which, for most public sector, was a novel approach for funding and procuring public services (Froud, 2003). Whilst public sector organisation struggled to understand the risks associated with PFI, they were further hampered by a lack of central guidance (Pollock et al, 2002). This resulted in public sector organisations trying to develop their own evaluation criteria. This has been both time consuming and costly, incurring high levels of professional fees (Akintoye et al, 2003). Retrospective reviews of specific projects therefore often noted that some risks had been transferred to the private sector that the public sector was better placed to take. Some of this could have been avoided through an improved knowledge of PFI risks within client teams and a more standardised approach to project and risk management (Akintoye et al, 2003; Asenova et al, 2002).

### **Lack of Required Skills in the Public Sector (PFI)**

Over time it has become evident that local authorities and other public sector bodies continue to struggle to become equal partners in PFI projects (Clark and Root, 1999). This appears to stem from a number of factors. Firstly, the PFI process inherently suffers from asymmetry of information (Asenova et al, 2002). The private sector partners already have all the technical skills required to complete the design, negotiations, construction and management of a new building as they are required to do this on a frequent basis. For the public sector partners, involvement in PFI is often a unique experience that challenges their commercial capabilities. In theory, public sector clients must lead the entire process if they do

not wish to be at the mercy of the contractors; but in reality many clients feel as though they are “walking in the dark” (Akintoye et al, 2003). Asenova et al quote one NHS Manager as saying that “building a hospital is a once in a lifetime experience” (Asenova et al, 2002). Similarly, HM Treasury publications note that skill shortages occurred in the healthcare sector, particularly in areas such as contract negotiation and project risk management (HM Treasury, 1999).

PFI contracts are legal arrangements that contain clauses designed to apportion risk equally between the two parties, the idea being that risks are managed by creating a balanced relationship through mutual dependence. It has been suggested that this dependence creates “incentives to make the relationship efficient and disincentives to behave opportunistically” (Lonsdale, 2005). The government advised public sector bodies entering into PFI contractual arrangements that this should be done on the basis of genuine partnerships aimed at optimising the sharing of risks. According to the Treasury (2003) “where this sharing of risks is done appropriately and effectively, it is the key to ensuring that the value for money benefits in PFI projects are realised”. In reality, it has become evident that the public sector does not always have the capabilities or resources required, to ensure that this balance is achieved (Lonsdale, 2005). Considering that the budget of some PFI projects has exceeded £100 million (Spackman, 2002), it is somewhat disturbing that these skill shortages continue to be apparent many years after PFI has been introduced.

### **Lengthy Negotiations and Complex Contracts (PFI)**

One specific criticism of PFI concerns the length and complexity of negotiations. Where projects have involved multiple partners and funding streams, PFI negotiations were renowned for being exceedingly long (Asenova et al, 2002; Akintoye et al, 2003), slow (Asenova et al, 2002) and complex (Akintoye et al, 2003). This has been attributed to a lack of experience on the part of public sector staff who appear to have required lengthy discussions with consultants in order to gain the required degree of understanding of the PFI process (Asenova et al, 2002; Akintoye et al, 2003) and/or lengthy time periods for arriving at decisions among multiple stakeholders (Asenova et al, 2002). Notwithstanding these problems, some research suggests that consultants may have exacerbated this by providing excessive levels of technical detail (Asenova et al, 2002; Akintoye et al, 2003), while some private sector partners were less forthcoming with detail, preferring a ‘black box’ approach (Akintoye et al, 2003).

Once the bidding process has identified a preferred bidder, as stated above, the negotiations may proceed for many months. Whilst there may have been a number of competitive companies seeking the PFI contract at the bidding stage, later this may not be the case, and the public sector bodies may not have the option of going back to original bidders. Consequently, a breakdown in negotiations would mean not just a repetition of the final bidding stage, but possibly another complete tendering exercise which could delay the project by months (NAO, 1999).

Lonsdale (2005) suggests that the difference between PFI contracts and more traditional government contracting is the general tendency for PFI contracts to contain greater levels of asset specificity and uncertainty compared with traditional contracting. Lonsdale believes this to be attributable to the bundling of services (discussed in more detail in the next section) and

the duration of the PFI contract which increases the asset specificity and degree of uncertainty respectively. Once a buyer has made significant transaction-specific investments they are in a weakened position unless they are able to write off those investments. Even though a buyer may have the legal right to walk away from a contract, the sunk costs of the investments and the cost of switching to an alternative provider may prove to be an insurmountable barrier. Consequently, the buyer may find themselves 'locked in' to the contract and struggling to proceed with the supplier in difficult circumstances (Lonsdale, 2005; Froud, 2003). This may also be true where the supplier threatens an increase to the agreed prices (Lonsdale, 2005). Whilst PFI contracts do contain termination clauses, it has been noted that they may be somewhat academic where there are practical barriers to existing the relationship (PAC, 2003; Lonsdale, 2005; Froud, 2003; Pollock et al, 2002). Gaffney, D. et al (1999) provide an example of this:

The recent crisis over private finance schemes for the new national insurance and passport agency computer systems (with private sector partners Siemens and Andersen Consulting) illustrate the problems. The Public Accounts Committee notes that the government's refusal to fine the contractors "would result in the risk purportedly transferred to Andersen Consulting under the PFI contract being transferred back to the public sector" (Committee of Public Accounts, 1999). This negates the key justification for the higher costs of the private finance initiative – the transfer of risk and the "efficiency" of the private sector.

Froud (2003) believes that the provision of public services through this type of medium-term contract increases the inflexibility of the public service, as managers are no longer able to make changes and redeploy their staff within and between units, thereby making the State less able to act. Froud claims that this inflexibility, and potentially increased cost, may also be passed on to "other parts of the public sector beyond the contracting organisation". If there is significant change in a product or service originally specified in the contract it will be necessary to change the statement of work provided under the terms of the contract. This argument is closely linked to Lonsdale's (2005) observation that that the supplier may see this as an opportunity to increase their revenue and, if the buyer has become 'locked in', they will be unable to threaten to return to the market (Lonsdale, 2005).

In essence both Froud (2003) and Lonsdale's (2005) would suggest that some of the risk management problems associated with PFI are systemic rather than being attributable to temporary skill shortages among public sector clients. This however, does not contradict the observation of other researchers who continue to attribute the slow pace of the negotiations typical of PFI projects to the public sector's bureaucratic attitudes" (Asenova et al, 2002; Akintoye et al, 2003; Stewart and Butler, 1996), prolific regulations (Stewart and Butler, 1996) as well as a (lack of) efficiency and validity of procedures (Clark and Root, 1999).

## **Structure (PFI)**

To "obtain the benefits of (allegedly) superior private sector management skills" (Lonsdale, 2005), many contracts bundle a variety of products and services that will be managed and coordinated by the primary contractor. This 'bundling' typically facilitates off-balance sheet treatment (Froud, 2003) but it also increases the asset specificity and

uncertainty as it brings together a number of different client requirements within one contract (Lonsdale, 2005). The PFI process often requires private sector partners to price their facilities management services in a vacuum during the bidding process (Akintoye et al, 2003). It also means that the supplier is involved with many aspects of the client's business and, consequently, it becomes more difficult to remove them even if the buyer has legitimate grounds under the terms of the contract. The purchase of full-service contracts poses further problems, as it requires clients to define the quality of service they expected. Without the required skills and experience to do this effectively, this can give rise to lengthy post-contract disputes (Akintoye et al, 2003).

The financial structure of PFI is very attractive to the government as they obtain the new infrastructure with minimal initial financial cost (Clark and Root, 1999; Spackman, 2002). However, this places a financial burden on the supplier who must then enter into lengthy contracts with the public sector bodies to recoup their investment (and increase their returns). Given the duration of the contract, it is necessary for the terms of the contract to be relatively vague and there is an expectation that the terms will be renegotiated at some point (Lonsdale, 2005). However, as already stated, during these renegotiations, the supplier is likely to have the upper hand knowing that the public sector body is unable to go back to the marketplace. With regard to risk management, this means that the public sector client faces undue burdens during both the procurement and the post-contract-completion phase.

### **Cost (PFI)**

When compared to projects purchased via traditional procurement methods many PFI projects involved higher purchase costs (Akintoye et al, 2003; Akintoye et al, 2003). This applies to the health sector in particular, where, in a 1996 survey of 202 NHS Trust Chief Executives, only 17 per cent believed that PFI would be cost-effective in the long term (UNISON, 1996). The same survey noted that even where a PFI project was shown to provide Value for Money, there was still a question of affordability as the hospital trust had to pay rent for the new facilities for the entire tenure of the contract which gave rise to a long-term affordability gap (UNISON, 2002).

Interestingly, private sector PFI participants have also noted that PFI, as a procurement process, imposes significant costs and risks on them. A series of interviews with private sector partners identified concerns over the high bidding costs they faced when competing for PFI contracts which were largely attributable to the cost of consultancy and legal services (Akintoye et al, 2003; Asenova et al, 2002). Moreover they noted that establishing and maintaining a consortium came at added cost and required time and effort (Akintoye et al, 2003). For the private sector PFI projects, moreover, often come with a high opportunity cost, since bidding for these contracts required greater efforts and resources to improve the chance of success, which could have been utilised for smaller and more numerous projects (Akintoye et al, 2003). When queried about the cost of PFI, private sector partners therefore noted that PFI bids placed a significant financial burden on them, which had to be recouped on consecutive projects (Asenova et al, 2002).

Notwithstanding the concerns of the private sector, there is evidence that the bidding process has placed significant demands on the resources of the NHS Trusts. Thus, the aforementioned 1996 UNISON survey notes that 76 per cent of NHS Trust Chief Executives

believed that the costs of preparing PFI bids were excessive (UNISON, 1996). There are also concerns that where a company becomes the preferred bidder, they may be in a situation where the public sector is 'locked in' and they can use this leverage to raise their prices (PAC, 2003).

Further concerns about the cost of traditional PFI projects have arisen in connection with the issue of project refinancing. After a project has been commissioned, banks may be willing to refinance for a longer term at a lower rate. Refinancing increases the expected dividends which will accrue to the shareholders. This has raised concerns about fairness to the taxpayer and in particular the need for refinancing gains to be shared fairly with the public sector client (Asenova et al, 2007; Spackman, 2002).

### **Building Quality (PFI)**

One of the expectations associated with the involvement of private sector partners in PFI projects was an improvement in both the design and quality of buildings in the NHS estate. The Commission for Architecture and the Built Environment, the Government's architectural watchdog, however, has raised concerns about the quality of design in PFI schemes (UNISON, 2002). Sunand Prasad, Commissioner at the Commission for Architecture and the Built Environment) claimed that "There is a legacy of sub-standard buildings in primary care and we are still, tragically, constructing buildings in PFI that are not buildings to be proud of in the future" (Davis, 2002).

Whilst some of the issues stem from the designs put forward by the architects, some blame has been laid with the public sector who, the private sector partners claim, have put forward either unclear or unreasonable demands which subsequently lead to delays and mistakes (Asenova et al, 2002; Akintoye et al, 2003). Notwithstanding this debate, there is also a strong possibility that risk averse attitudes among private sector investors in PFI projects have militated against the adoption of innovative design solution.

## **LOCAL IMPROVEMENT FINANCE TRUSTS (LIFT)**

PFI in the health service was initially conceived as a means for procuring new hospital infrastructure for the health service. More recently, there has been a growing recognition that similar improvements were required in the primary care sector. However, since GP-owned premises are usually relatively small, their procurement or refurbishment does not typically represent the type of project that would appeal to private sector PFI investors. In response to this issue, in 2001 the Department of Health (DoH) introduced its new Local Improvement Finance Trust (LIFT). A key component of LIFT is an exclusivity clause giving the successful LIFTCo the right to build all primary care premises for a Primary Care Trust (Aldred, 2007). As a consequence, the LIFT process removes the need to go out to tender for construction projects in the future as all facilities can be delivered by the same local LIFTCo (Ballantyne, 2005; Little, 2006). It is assumed that this ensures good quality bids for relatively small capital schemes and can save on bid costs (Ballantyne, 2005). However, the House of Commons Committee of Public Accounts identified that

For the LIFT model to work efficiently there needs to be a continuous flow of developments. The LIFTCo is intended to operate as a local property development business with overhead costs spread over a number of projects. Given the cost to the local health economy of developing LIFT buildings, and the long term funding requirements, there is a risk that a continuous flow of projects may not be taken forward. If so, the model may not achieve the expected benefits (House of Commons, 2006).

But ignoring this possibility, is there evidence that LIFT can address the risk-management related shortcomings of PFI? The following sections address each of these issues in turn.

### **Poor Risk Management (LIFT)**

In interviews with members of public sector bodies undertaking LIFT projects, Aldred (2008) noted that they believed that private sector companies, “in particular banks”, were highly risk averse and suggested that “the public sector may not get good value for money when attempting to transfer risk to the public sector”. The Public Accounts Committee (PAC) recognised that the returns for LIFT were perceived to be very high in relation to the level of risk assumed by the private sector partners, a fact confirmed by Holmes et al (2006) who felt that “contractors involved in the LIFT process are making a greater return on their investment than the much-criticised PFI schemes”. However the PAC argues that this may have been the case in the early schemes “because of perceived greater risk associated with the newness of the schemes, and uncertainty over the pace of future developments” (HoC, 2006). This view has been confirmed by the NAO (2005) who noted that the returns should reduce over time as learning curves are overcome.

Notwithstanding this expectation, criticisms are still being voiced with regard to the risk premium achieved by LIFT companies, with UNISON (2006) claiming that “the projected LIFT rate of return of 15.1% on average compares with 8-9% for traditional third party development – a lot of extra profit given that a PCT may pay around £1 million per year or more to lease each LIFT health centre”. Others, like Dawson (2001) would argue that a 15% return should be considered standard for a low-risk, privately financed project. Overall, there appears to be little agreement as to how private sector companies involved in LIFT projects should be rewarded for the risk of their investment. As of now, the going rates of return for LIFT projects appear to have ensured adequate market interest from the private sector, but there is every possibility that this has been achieved at the cost of excessive risk premia.

### **Lack of Required Skills in the Public Sector (LIFT)**

Whilst the Primary Care Trusts have little, if any, experience of property (re)development and management, the consultants required to assist them with those critical skill sets (Hines, 2003) have little, if any, experience of health care and special requirements in terms of design and specifications. In their study, the NAO (2005) found that PCTs found the development of plans understandably “complex and time consuming”. According to Holmes et al (2006) this “inequality in the size and expertise of the negotiating parties has given the upper hand to the

contractors when discussing technical specifications and operational arrangements”. To try to overcome this, the PCT requires a project team that is adequately resourced with the appropriate skills and management/leadership support (Hines, 2003). Although this may seem a basic requirement, according to the NAO (2005), 56 per cent of PCTs felt that they did not have sufficient resources to complete their project efficiently. Whilst some authorities provided centralised resources to assist with this process where they had several concurrent LIFT projects, other authorities were slower in providing this support (Ballantyne, 2005). Like the public sector bodies procuring facilities under the PFI, it would seem that the PCTs struggle with developing the capabilities necessary to enter into the required bilateral contracts and partnerships with the private sector.

### **Lengthy Negotiations and Complex Contracts (LIFT)**

There is evidence that the bidding process creates particular difficulties to all parties involved in LIFT procurement. Andalo (2003) noted that LIFT requires the submission of detailed plans very early in the process which significantly increases costs for potential bidders. Gaining sign-off is also perceived to be a “pretty painful process” (Sansom, 2007). Little (2006) notes that for one super surgery “the planning took several years” and for one LIFT project Parker (2006) claimed that the process lasted for two years:

Three consortia were picked to bid, one dropped out halfway through. It took six months for the LIFT to get a preferred bidder, then a year until financial close.

Consequently, some individuals involved in the process have queried whether the process could be streamlined and whether the front-end planning costs could be reduced as they current act as a deterrent (Meara, 2001).

LIFT “represents a shift in the way governments contract with private firms: from short-term, discrete contracts, to long-term, complex and open-ended contracts” (Aldred, 2007). Such contracts are inherently complex, and perhaps unsurprisingly, a UNISON report (2006) has suggested that “The extra layers of bureaucracy diminish the ability of NHS directors and managers to control the services provided and make it still harder for patients and staff to make their voices heard”.

Negotiations with local health care providers seems to have taken longer than expected with varying degrees of success in gaining buy-in to the process (NAO, 2005). Even when the buildings are occupied, health care professionals working within LIFT buildings have noted that the terms of the contracts make it difficult and expensive to undertake minor alterations to the property once it has been completed (HoC, 2006) as “the lease agreement states that tenants can only do so with prior consent of the LIFTCo, but the time delay and bureaucracy involved in getting LIFTCo approval often causes frustration”.

The scale of some combined LIFT projects means that companies bidding for the work must go through a detailed procurement process governed by European legislation. This means that a bidding company must have the requisite skills and adequate resources not only to complete the job, but also to develop and fund expensive, and potentially unsuccessful, bids (Hudson et al, 2003; Holmes et al, 2006). Holmes et al (2006) suggest that submitting a bid may cost an organisation between “£500,000 and £1 million, with only a one-in-three

chance of success". Consequently, some smaller developers are unable to compete and are squeezed out by the large development companies (Hudson et al, 2003). However, these larger, often national, companies often have higher overheads which can be a significant factor in the overall construction costs of the schemes (Hudson et al, 2003; Holmes et al, 2006).

Some private partners consider the pressure of the bidding process as "too onerous"; with one company Managing Director stating that "I think that the selection process is asking too much. Originally we had been asked to develop 11 schemes over two months. We managed to compromise and agreed on six, but this is still a huge amount of work bearing in mind that one scheme alone was worth £12m" (HD, 2003). This Managing Director believes that the selection process should be refined so that the preferred bidder is chosen on the design approach and track record rather than the actual design (HD, 2003). Another developer is quoted as saying "the process is very lengthy and it puts pressure on medium-sized organisations. You can't go forward to the next bid" (HD, 2003).

Given the duration of the LIFT negotiation process, and the cost involved, it would seem likely that the public sector bodies would be reluctant to withdraw from the process and return to the marketplace. Consequently, like PFI, LIFT may well place the PCTs at risk of becoming locked-in to the process and committed to the preferred bidder irrespective of any decline in their relationship.

### **Structure (LIFT)**

By grouping a number of projects together and including the long-term operation and management of these facilities, the scale of each initiative is increased considerably, making them viable and attractive to private investors (Hudson et al, 2003; Holmes et al, 2006; NAO, 2005). One example of this is a project where a company is providing design services on a range of schemes forming part of a £125 million programme to deliver over 40 health care centres (HD, 2006a). Another project will provide nine new healthcare centres, a 72-bed care home for the elderly, a new HQ for the lead primary care trust as well as additional facilities in the first 18 months (HD, 2006a). Other examples include an integrated health and leisure scheme in Burnley where an eleven storey building of 12,600 sq. m. housing a health centre shares a common entrance and reception with a three storey, 5,000 sq.m. leisure centre. In Knowsley, a new LIFT centre will accommodate three GP Practices, council services, a library, a treatment centre offering extended hours and will facilitate local access to a range of new health services including a cardiac clinic. Similarly, the new Halewood Health and Social Care Centre is contributing to complete town centre regeneration and, in addition to extended clinical services, will offer a café, access to housing trust and town council offices, a library, post office, Citizens Advice Bureau and community meeting rooms. However, as stated earlier, bundling can also increase the risks associated with asset specificity and uncertainty. In health care, a PFI contract is typically with a single Trust for one building and the services contained within it. However, under LIFT - as the examples above demonstrate - the contract is often for multiple buildings with many tenants who may have competing demands.

As would be expected, the financial structure of LIFT is very similar to that of PFI. As already stated, by bundling various smaller projects into one contract, LIFT increases the

value of the contract to make it attractive to investors. This then replicates PFI by placing a heavy financial burden on the suppliers who must enter similar long-term contracts with the public sector to recoup their investment. Although, like PFI, the private sector has the benefit of knowing that it would be very difficult for the public sector to withdraw from the contract once they are committed.

### **Cost (LIFT)**

The funding mechanism behind LIFT has been described as “very complicated” (Tyndale- Biscoe, 2003). With the current lack of any form of evaluation, it is understandable that costs associated with the LIFT process are being questioned, from initial set-up (Tyndale-Biscoe, 2003), fees payable to Partnerships for Health (NAO, 2005), and operating costs (Comerford, 2004) to the rents being charged to tenants (Holmes et al, 2006). The House of Commons (HoC) Public Accounts Committee has stated that “Primary Care Trust accommodation spending on patients registered with GPs in a LIFT development is up to eight times higher than total primary care spending on accommodation. The difference mainly reflects the cost of providing new, high quality and purpose built buildings” (HoC, 2006). Given this analysis, it is understandable that the Chairman of this committee argued that

What we really need to know is whether the expected benefits to patients justify the cost of using LIFT to provide the new facilities. Providing new, purpose-built buildings for GPs and other primary care services is obviously going to be more expensive than carrying on with older premises. (Guillochon, 2006)

In an interview with a mental health trust director, it was revealed that one financial institution had imposed insurance charges of more than double the usual rate, and these costs had been passed on to the NHS organisations involved (Aldred, 2008). Others perceive LIFT as being effective but costly and drawn out (HD, 2006b), suggesting that these two characteristics will prevent the public sector from walking away from a contract if they run into difficulties.

In the past the NHS, and individual GPs, could choose to reduce immediate expenditure by deciding to postpone building maintenance, or the replacement of equipment. With the advent of LIFT this no longer remains an option as all maintenance now falls under the remit of the LIFTCo contract and the PCT will automatically have a share of these charges routinely included in their fees (Dawson, 2001). Similarly, whilst PCTs and GPs may have chosen to expand or refurbish premises on a piecemeal basis, with LIFT new buildings are delivered in entirety committing the PCT, and their tenants, to their maximum rent immediately with no potential for any phasing (Dawson, 2001). Both factors are likely to raise overall costs but there is also a possibility that they will contribute to higher levels of maintenance and higher residual values.

## **Building Quality (LIFT)**

The implementation of LIFT has kick-started the regeneration of primary care premises on a major scale. For example, in Merseyside alone it is envisaged that there will be 30 schemes with a total value of £100 million (Burton, 2004). Given that many GP practices were housed in poor accommodation with only 40% of premises purpose built, and almost 50% in either converted shops or former residential buildings (Montague, 2004), the government has high hopes for LIFT-built premises. However, in the main, there is no evidence that this has been the case. One author goes so far as to state that “LIFT as a vehicle, is not necessarily producing very much better buildings. Generally speaking, they are mediocre at best” (Simpson, 2007). Peter Wearmouth, chief executive of NHS Estates, identified a lack of innovation in design and said

We are still designing buildings that look the same as they did 30-40 years ago. We still have waiting rooms and consulting rooms, but society has changed. Patients are no longer submissive yet we build architecture that is submissive.(Davis, 2002)

Mathieson (2003) confirms this view by describing one proposed centre with five stand-alone GP surgeries, each with their own waiting room. Even Lord Hunt, Ministerial Design Champion is quoted as saying “It is striking how unambitious the health service has been in the quality of the design of what it produces” (Davis, 20028). Prasad supported the aims of the NHS Achieving Excellence in Design evaluation Toolkit, intended by NHS Estates to raise the general standards of design in the NHS building programme, but conceded that it would not ‘produce genius designs’ (Davis, 2002). Whilst this lack of “flair” was perhaps understandable during the first wave where the impetus was to get the first projects completed (Parker, 2006), it is less acceptable for these issues to characterise later projects.

Designing for a health care market was something new for most architects and design companies (Holmes et al, 2006) and seems to have posed some challenges. These challenges included the need to take into account the “unique aspects of each centre such as the acoustic features for those which had audiology departments, the need to develop bespoke characteristic entrances to each site” (HD, 2006) as well as the security concerns of staff (Holmes et al, 2006). Whilst it was recognised that the health service did not “want to make the same mistakes as we did in the 1950s and 1960s” when “we built health centres, which are now unloved buildings surrounded by security fences and covered in graffiti” (Andalo, 2003), some initial designs were likened to ‘car show-rooms’ or ‘prisons’ by lay stakeholders (Holmes et al, 2006).

Whilst the multi-disciplinary, open-layout approach to working in some new LIFT buildings has created a “sense of community spirit” that has been well received by some (Gilbert, 2005), it has also created problems. For example, in one location the creation of a centralised reception area for four physician practices has reduced patient privacy as any discussion with the medical secretaries can be easily overheard (Gilbert, 2005). There have also been basic oversights, such as the lack of a patient call system so doctors must leave their rooms to call in their next patient, insufficient car parking spaces and a common alarm system that prevents GPs from calling in to their practice to work out of hours (Gilbert, 2005).

The LIFT process is credited with attracting national construction and design teams (Holmes et al, 2006.) and for facilitating attention to detail, such as the creation of a design

with features to maximise light and ventilation (Montague, 2004). However, bringing this “sophisticated design expertise” into the procurement process also brought negotiation teams into the bidding process who “used this experience to drive a hard bargain with the PCT teams for whom each negotiation was a first” (Holmes et al, 2006). Today private sector partners claim that they are “on the hook” to deliver “decent buildings” that are “affordable”, “efficient” and “good-quality” whilst being “architecturally-striking civic landmarks” (Sansom, 2007). At the same time there are economic incentives for the private partner to design and build in a way that will minimise costs (Dawson, 2001). This is related to worries that LIFT will inadvertently lock the health service may into inflexible contracts for poorly constructed building with high operating costs for the next 25 years (Paxton and Lissauer, 2000).

## NEW ISSUES CREATED BY LIFT

According to the literature, the LIFT scheme seems to replicate many of the problems associated with the PFI procurement process. In addition there is some evidence that, as a significant modification of PFI, LIFT suffers from specific new difficulties.

### Control

Whilst with PFI the public sector retains responsibility for deciding on the public sector services to be provided, the quality and performance standards of these services, and taking corrective action if performance falls below expectation” (Akintoye et al, 2003) the same is not true for all LIFT projects. New language in LIFT contracts authorises some LIFT companies to “privatise clinical services in LIFT and non-LIFT buildings” by getting them to “engage private medical companies to provide GP services, or agencies to provide district nursing services” (UNISON, 2006). Assuming that LIFT companies do engage others to provide these services, there are fears that such deals would be “shrouded in ‘commercial confidentiality’” and embedded in highly complex, long-term contracts making it impossible for others to intercede, even if public safety was at stake (Aldred, 2005). There are also concerns that the planning function of the NHS will be further eroded and allowing the LIFTCos to determine how, and by whom, service will be delivered (Aldred, 2005). Hellowell (2004) quotes Brian Johns, chief executive for Partnerships for Health, as saying:

The department is not yet clear on the best way to take this forward. It could be that a new-wave LIFT company would be expected to build clinical services into its delivery model – perhaps even taking financial risk on clinical outcomes as in the elective care programme. More likely, LIFT companies would be expected to procure clinical services such as diagnostics and out-of-hours services as part of the supply chain. Interestingly, this is not an innovation that existing private sector players in LIFT are keen on.

Similarly David Toplas, Chief Executive of Mill Group, a prominent investor in the LIFT programme, believes this would “make many people think again about their involvement in LIFT” (Hellowell, 2004).

Under current contractual arrangements, LIFT companies can determine which private businesses are able to move into their buildings. This is of some concern to the GPs. As one GP noted in an interview with Dix (2001), they did not want to see a “McDonald’s next to the waiting room” as had already appeared in some NHS hospitals (UNISON, 2006). Some LIFT project managers have negotiated the right of veto to ensure that the public sector partner can determine who is allocated a tenancy agreement. In one such project the co-ordinator explained that other complementary shops and services could rent spaces on the site, such as social housing related activities, opticians, dentists and pharmacies. They may also allow third party revenue generation from private businesses such as “a veterinary practice, but not a tobacconist. We wouldn’t have betting shops, but retail outlets complementary to health might be accepted such as health food outlets” (Mathieson, 2002).

It is recognised that the public sector will be forced to consider how the profitability of new premises can be maximised whilst enhancing the services available to the local population (Aldred, 2007). However, it may be hard to ignore the fact that “The more professionals you cram into a one-stop shop, the more profitable the site” (Andalo, 2003).

### **Conflicts of Interest**

In an NAO study, two thirds of Primary Care Trust Chief Executives or Finance Directors had been appointed to act as public sector directors on their LIFTCo (NAO, 2005). In their employment contracts these individuals have a duty to protect the interests of the PCT, such as minimising the costs of purchasing services from the LIFTCo. However, their new roles with the LIFTCo would require them to act in the interest of the LIFTCo board, including maximising profits for the shareholders. This could create a potential for conflict of interest (Unison, 2006; NAO, 2005). There are similar concerns over potential conflict of interest for GPs who become members of a local LIFT Company and who are required to act in the best interest of their patients (Mathieson, 2002). The King’s Fund (2001) notes that whilst the private sector will be “seeking to develop sites with profitable complementary uses... the public shareholders will be seeking to ensure good locations and a good mix of (non-profit making) users”.

Similarly, the recruitment of independent non-executives to Chair the PCT and strategic Partnering Boards has proved difficult for many LIFT areas (NAO, 2005). Whilst it is recognised that there is a need for the board to have the requisite skills to protect public interests, in practice this has resulted in the recruitment of individuals with conflicting interests. In one third of the NAO case studies the Chair of the Strategic Partnering Board was a local stakeholder in LIFT (NAO, 2005) who could clearly have an influence on the bidding process (Tyndale- Biscoe, 2003).

### **Use of Enabling Funds**

To facilitate the start of LIFT projects, the Government made ‘enabling funds’ available to the projects to “remove obstacles to a project going ahead by, for example, purchasing sites or releasing GP practices from negative equity” (Hines, 2003). These funds could also be used to reconvert primary care premises back into residential premises in order to make them

more attractive to the market and easier to sell if the GPs were prepared to relocate into LIFT premises (DoH, 2000). These funds are “not automatically refundable”. However, in the limited guidance provided by the Government, it was stated that “there may be circumstances in which the Department would be keen to reclaim funding to enable it to be recycled into further LIFT developments” (NAO, 2005). The NAO go on to state that one third of project managers were uncertain as to how to use the enabling funds, leading to “variation” in usage (NAO, 2005). The NAO also notes that as of January 2005, “no funds have been paid back to the Department. This has prompted a review of the efficiency of how funds are used and recycled”.

Whilst the LIFT process was supposed to reduce the involvement of the PCTs in the construction and day-to-day management of the buildings, it would seem that they are still required to take on the initiation and management of revenue contracts, including undertaking “all the leg work, paying solicitors’ costs, accountants and consultants when they set them up” (Comerford, 2004); costs which Comerford claims are higher than those under the previous system of fixed cost or notional rent. Whilst this may be done using the enabling funds, it is still an additional cost in the process.

## Revenue

Rental income has, understandably, been a consideration of developers given the significant opportunities for revenue raising (Paxton and Lissauer, 2000). Some have designed and built more traditional GP surgeries, preferring GP stability and steady rental income over multi-use facilities with “more risky tenants” (Mathieson, 2002). It is interesting to note that at one LIFT project, the LIFT coordinator has chosen not to discuss rents with its GPs as:

It does not want them to become alarmed over figures that are still being discussed: the bidders have put indicative rental figures in their bids and we are in negotiation with them over those figures (Dudman, 2003)

This suggests that the rent could be considerably higher than the GPs would anticipate. Holmes et al (2006) describe the major concern over rents to be paid by tenants of LIFT buildings by stating that “there is a perception that the higher costs of LIFT, compared to current rent payments, outweighs the benefits of new, purpose-built premises”.

UNISON (2003) notes that LIFT companies have to pay back the capital borrowed to fund the development, pay to maintain the buildings and must still make a profit for investors; and that all of these costs must be reflected in the rents charged to the PCT and other tenants. Holmes et al (2006) note that there are hidden costs associated with unsuccessful bidders which need to be “built into other rounds”. It is not surprising that the PCTs are being charged a higher rent than their previous market-rate cost-rents which, according to Comerford (2004), amounts to an eight to ten per cent increase.

Obtaining tenants for all LIFT spaces has not been as straightforward as it may be perceived. Some GPs, including those approaching retirement age, are not in a position to sign a 25 year tenancy agreement. PCTs can take over a head lease with the developer and then sub-let to GPs or other tenants on a shorter-term basis; an option which may be more

attractive to practitioners (Paxton and Lissauer, 2000; Unison, 2003; Aldred, 2007) including those who wish to work in an inner city location or to obtain new skills before relocating elsewhere (Sansom, 2007). However, this leaves the NHS at risk of GPs either leaving or defaulting (Aldred, 2007; Aldred 2008) or coming to the end of their lease and the PCT being unable to find a replacement tenant (Unison, 2003).

These concerns have been examined by Aldred (2007) who interviewed a number of dentists, pharmacists and local authority representatives. Holmes (2006) goes on to say that “In the case study area the rent charged for the new LIFT premises is in the order of £210/m<sup>2</sup>. Similar, if not superior accommodation provided by the third party procurement is in the region of £160/m<sup>2</sup>. When a comparable facility management package is added, the rent from a third party developer will be approximately 175-190/m<sup>2</sup>. In real terms, the facilities provided are expensive when compared to market rents in the locality”. For this reason it is suggested that local authorities and allied health practices, including pharmacies and dentists, have chosen not to rent spaces in the LIFT buildings, preferring in some cases to rent retail premises adjacent to the doctor’s practice at a “considerably” lower rent (Holmes et al, 2006). The reason pharmacies in particular may not wish to relocate into a LIFT building was identified by the NAO (2005) who stated that, whilst primary care providers such as dentists and doctors receive some automatic reimbursement for the rent paid for primary care premises, the PCT determines whether a pharmacy is similarly classified. In the main pharmacies tend to be considered a business and as such will be expected to pay full rent for their space. As the NAO (2005) identifies that pharmacies are “likely to be the most significant source of third party income” which can be used to “plug funding gaps and reduce the rent levels paid by other tenants”, pricing them out of the market would seem to be a short-sighted approach. This may be why alternatives such as cafes, vending machines, internet training facilities and complementary therapists are now being encouraged to locate within the space. There is evidence that in order to encourage healthcare professionals to relocate into LIFT premises, some PCTs have now even agreed to subsidise rents (NAO, 2005).

## CONCLUSIONS

Whilst it is evident that the PFI process had inherent risk-management issues, there are strong suggestions that the LIFT process has not fully addressed these. It would seem that the public sector is still struggling to identify the risks associated with a PPP project. They still do not appear to have the resources required to be on an equal footing with their private sector partners and to enable them to undertake their part in the procurement process efficiently and effectively. There are also ongoing concerns over whether using some form of risk-transfer mechanism through a contract can truly protect the public interest, especially given the difficulties encountered within the public sector when trying to identify risks in the first place.

If the literature is correct, LIFT would seem to have created additional problems including the further reduction of public sector control, conflicts of interest, the inappropriate use of enabling funds, and higher than market rental costs affecting the uptake of space in the buildings by local health care providers. Furthermore, there are ongoing concerns about the high costs of the bidding and procurement process and the complexity of the contractual

negotiations and arrangements. Some of these problems have been addressed by individual PCTs who have engaged in a bundling of projects and/or partnerships with other PCTs in the procurement of LIFT projects and the creation of LIFT companies. While these measures are likely to reduce transaction and bidding costs as well as having a potentially positive impact on the Value for Money, they also increase the possible exposure of PCTs to lock-ins and their vulnerability to private sector financial failure. Overall there is therefore an urgent need for PCTs to gain awareness and skill in the management of the unique risks this form of public-private partnership poses.

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### REFERENCES

- Akintoye, A., Hardcastle, C., Beck, M., Chinyio, E. and Asenova, D. 2003 Achieving Best Value in Private Finance Initiative Project Procurement, *Construction Management and Economics*, 21: 461-470.
- Aldred, R. 2005. Challenges of Private Provision in the NHS: Real Story is Beginning to Emerge, *British Medical Journal*, 331: 1338.
- Aldred, R. 2008. Managing Risk and Regulation Within new Local 'Health Economies: The Case of NHS LIFT, *Health, Risk and Society*, 10(1): 23-36.
- Aldred, R. 2007. Closed Policy Networks, Broken Chains of Communication and the Stories Behind an 'Entrepreneurial Policy': The Case Of NHS Local Improvement Finance Trust (NHS LIFT), *Critical Social Policy*, 27(1): 139-151.
- Andalo, D. 2003. 'One Stop to Cure All Ills, *Medeconomics*, 24(1): 16-18, 20.
- Asenova, D., and Beck, M. 2003. The UK Financial Sector and Risk Management in PFI Projects: A Survey, *Public Money and Management*, 23(3): 195-203.
- Asenova, D., Beck, M., Akintoye, A., Hardcastle, C. and Chinyio, E. 2002. Partnership, Value for Money and Best Value in PFI Projects: Obstacles and Opportunities, *Public Policy and Administration*, 17(4): 5 – 19.
- Asenova, D.; Beck, M and Toms, S. 2007. The Limits of Market-Based Governance and Accountability – PFI Refinancing and the Resurgence of The Regulatory State, paper presented at the 7<sup>th</sup> European Critical Accounting Studies conference, University of Glasgow.
- Audit Commission. 1998. Taking The Initiative: A Framework for Purchasing Under the Private Finance Initiative. London, Audit Commission.
- Ballantyne, N. 2005. Getting Lift off the Ground, retrieved October 23 2007 from [www.cipfa.org.uk/publicfinance/news\\_details.cfm?News\\_id=25327](http://www.cipfa.org.uk/publicfinance/news_details.cfm?News_id=25327).

- Beck, M. and Hunter-Beck, C. 2003. PFI Uptake in UK Local Authorities, in A. Akintoye, M. Beck and C. Hardcastle (eds.) *Private Partnerships: Managing Risks and Opportunities*. Oxford, Blackwell Science.
- Bunce, C. 1997. Laying the Foundations for a GP-led study, *General Practitioner*, Feb 24: 32-33.
- Burton, R. 2004. Regeneration Game, *Hospital Development*, 35(6) pp 11-13.
- Clark, G.L. and Root, A. 1999. Infrastructure Shortfall in the United Kingdom: the Private Finance Initiative and Government Policy, *Political Geography*, 18: 341-365.
- Comerford, C. 2004. Is .108m of Premises Funding Just Papering Over the Cracks? *Doctor*, Aug 20: 10.
- Committee of Public Accounts (1999) *Twenty-third Report: Getting Better Value for Money from the Private Finance Initiative*. London, House of Commons Committee Office.
- Daily Telegraph. 1996. Whitehall PFI Taken Into its Next Phase, April 4: 19.
- Davis, K. 2002. *Primary Concerns*, *Hospital Development*, 33(6): 8-9.
- Dawson, D. 2001. The Private Finance Initiative: a Public Finance Illusion? *Health Economics*, 10(6): 479-486.
- Dix, A. 2001. Delayed LIFT-off... (Local Improvement Finance Trust), the Replacement or Refurbishment of 3,000 GP Premises and 500 'one-stop health centres', *Health Service Journal*, 111(5752): 1-3.
- Department of Health. 2000. *New Initiatives to Modernise GP Premises*. London, Department of Health.
- Department of Health. 2001. *NHS Local Improvement Finance Trust (NHS LIFT) Prospectus*. London, Department of Health.
- Dudman, J. 2003. Ready for Lift-off, *Public Finance*, Feb 7: 24-25.
- Froud, J. 2003. The Private Finance Initiative: Risk, Uncertainty and the State, *Accounting, Organizations and Society*, 28: 567-589.
- Gaffney, D., Pollock, A.M., Price, D. and Shaoul, J. 1999. The Private Finance Initiative: The Politics of the Private Finance Initiative and the New NHS, *British Medical Journal*, 319: 249-253.
- Gilbert, H. 2005. Super Size Me, *Care and Health Magazine*, 104: 20-22.
- Guillochon, R. 2006. MPs say Government Scheme for GPs' Premises Threatens Other Primary Care Needs, *British Medical Journal*, 333: 64.
- Hospital Development . 2003. East London LIFT Raises Questions, <http://www.hdmagazine.co.uk/story.asp?storyCode=2018286>.
- Hospital Development . 2006a. WYG Supports £124m LIFT Project, <http://www.hdmagazine.co.uk/story.asp?storyCode=2035925>.
- Hospital Development . 2006b. Design Improved under PFI, <http://www.hdmagazine.co.uk/story.asp?storyCode=2036179>.
- Hellowell, M. 2004. PPPs in Perspective - Uplifting Experience, *Public Finance*, 24: 23.
- Hines, C. 2003. How LIFT is Helping Cornwall Experience a Taste of Eden, *Primary Care Report*, 5(3): 22-23.
- HM Treasury. 1999. *Modern Government, Modern Procurement*. London, HM Treasury.
- HM Treasury. 2003. *PFI: Meeting the Investment Challenge*. Norwich, HMSO.
- HoC. 2006. *NHS Local Improvement Finance Trusts: Forty Seventh Report of Session 2005-06*. London, HMSO.

- Holmes, J., Capper, G. and Hudson, G. 2006. Public Private Partnerships in the Provision of Health Care Premises in the UK, *International Journal of Project Management*, 24(7): 566-572.
- Hudson, G., Capper, G. and Holmes, J. 2003. The Implications of PFI on Health Care Premises, Engineering\_Design, Durability, and Maintenance, London, Institution of Mechanical Engineers Conference.
- Little, W. 2006. Primary care. Settle for Super, *Health Service Journal*, 116( 6000): 26-8.
- Lonsdale, C. 2005. Risk Transfer and the UK Private Finance Initiative: a Theoretical Analysis, *Policy and Politics*, 33(2): 231-249.
- Mathieson, S. 2003. LIFT-long Learning, *Health Service Journal*, 113(5850): 33-35.
- Meara, R. 2001. Do we Have Lift-off, *Private Finance Initiative*, 6(2): 76-78.
- Montague, A. 2004. A LIFT for local communities, *Hospital Development*, 35(9): 19-20.
- National Audit Office. 1999. *The PFI Contract for the New Dartford and Gravesham Hospital*. London, NAO.
- National Audit Office. 2005. *Innovation in the NHS: Local Improvement Finance Trusts*. London, The Stationery Office.
- Parker, J. 2006. Street Life, *Hospital Development*, 37(1): 18-19.
- Pollock, A.; Shaoul, J. and Vickers, N. 2002. Private Finance and “Value for Money” in NHS Hospitals: a Policy in Search of a Rationale? *British Medical Journal*, 324(7347): 1205-1209.
- Private Finance Panel. 1995. *Private Opportunity, Public Benefit: Progressing the Private Finance Initiative*. London, HMSO.
- Private Finance Panel. 1996. *Private Finance Initiative: Guidelines for Smoothing the Procurement Process*. London, HMSO.
- Public Advisory Committee. 2003. *Delivering Better Value for Money from the Private Finance Initiative*. London, Public Accounts Committee.
- Sansom, A. 2007. London LIFT Projects: Meeting of Minds, *Hospital Development*, <http://www.hdmagazine.co.uk/story.asp?storyCode=2041823>.
- Simpson, V. 2007. Primary and Community Care: Changing Faces, *Hospital Development*, <http://www.hdmagazine.co.uk/story.asp?storyCode=2041695>.
- Spackman, M. 2002. ‘Public-Private Partnerships: Lessons from the British Approach, *Economic Systems*, 26: 283-301.
- Stewart, A. and Butler, E. 1996. *Seize the Initiative*. London, Adam Smith Institute.
- The King’s Fund. 2000. *Health Care UK*. London, The King’s Fund.
- Treasury Taskforce. 1997. *Partnerships for Prosperity: The Private Finance Initiative*. London, HM Treasury.
- Treasury Taskforce. 1999. *Standardisation of Contracts*. London, HM Treasury.
- Tyndale Biscoe, J. 2003. Why LIFT isn’t Hitting the Mark, *Medeconomics*, 24(5): 26,29-31.
- UNISON. 1996. *NHS Trust Chief Executives Give Thumbs Down to PFI*. London, UNISON.
- UNISON. 2002. *PFI: Failing Our Future - A UNISON Audit of the Private Finance Initiative*. London, UNISON.
- UNISON and R. Aldred 2006. *In the Interests of Profit at the Expense of Patients: An Examination of the NHS Local Improvement Finance Trust (LIFT) Model, Analysing Six Key Disadvantages*. London, UNISON.