Evolution of Public-Private Partnership: The UK Perspective through a Case Study Approach

ABSTRACT

Purpose: Since the 1990s, the NHS advisory officers have developed considerable expertise in managing the process of specifying, procuring, contracting and running PPP projects. However, there has been a relatively consistent trajectory in the findings of studies and evaluation of PPP from its initial introduction in the health sector in 1992 to the present time. Therefore, the purpose of this study is to critically evaluate the PPI experience in the UK context using a case study in the NHS.

Design/methodology/approach: The partnership literature is primarily focused on process issues, and the impact of partnerships on improving outcomes cannot be assumed. By conducting a critical review on most updated research studies and innovative approaches in this area, we will critically explore the literature as to the place of Public-Private Partnerships in health in the context of the UK and see if they have a role in system resilience. A case study has be used as well to describing the processes of a PPP arrangement.

Findings: Healthcare PPP is one of the options relating to health system resilience. However, their contribution in the NHS has been mixed, with success noted in short term clinical and services contracts while in the long term the value for money argument has not been proven. In theory, the role of PPPs in bringing together ingredients supporting system resilience such as finance, management and innovation in the UK has not always been successful, and NHS providers have taken the approach to exit such arrangements.

Research limitations/implications: More research work is needed to capture the 21st-century challenges and Critical Success Factors during its implementation.

Practical implications: The creation of strong partnerships is moving service delivery away from a project-by-project approach to one that includes strategic and policy developments for long-term results.

Originality/value: This is a fresh discussion in the role of PPI in system resilience in the UK perspective through a case study describing an exit from a PPP arrangement

Keywords: Public-Private Partnerships, UK, Governance, Management, Policy Development

1. INTRODUCTION

The term public-private partnership (PPP) covers a wide variety of ventures involving a diversity of arrangements, varying with regard to participants, legal status, governance, management, policy-setting prerogatives, contributions and operational

roles (Allen, 2018; Widdus 2001). This partnership is defined as a "long-term contract between a private party and a government agency for providing a public asset or service" (Institute, 2012) and in the health sector, WHO describes the partnership as a means to "bring together a set of factors for the common goal of improving the health of populations based on mutually agreed roles and principles' (Kickbusch and Quick, 1998).

PPP is one method Governments use to procure and deliver public infrastructure, with other ones being public procurement through fixed-price contracts or managing the contractor directly (Reynolds, 2017; Grimsey and Lewis, 2007). With traditional procurement, private companies have long been involved in building roads, hospitals, schools and public buildings, and in providing management and maintenance services. Traditional procurement incorporates all or several of the following features:

- A tender evaluation process weighted in favour of lowest procurement cost
- A project specification issued by government agencies and their advisers that provides an absolute requirement of the goods and services to be supplied by the contractor. In the case of buildings, this will generally refer to the design, the method of construction, the finishes and equipment levels.
- The procurement will be required to comply with standard state procurement policies and protocols
- An adversarial contractual framework
- Separation of the design, project management and construction tasks.

What differs with a PPP is that these separate arrangements are combined (bundled) into one contract and a private sector entity charged with providing, not a building, but a flow of infrastructure services over time. As such, PPP was being seen as an attractive procurement solution which could bring benefits with respect to risk allocation, certainty, incentives, intergenerational equity and fiscal sustainability, and the cost of capital (Regan, Smith *et al.*, 2011).

Tenders for PPPs are conducted for either the private provision of an asset for state use on a take-or-pay basis (for example, the provision of a serviced hospital bed) or the private delivery of services to or on behalf of the government (for example, the

contact and trace service for COVID-17) or the private provision of an asset on a market-risk user-pays basis (for example, a toll road). Furthermore, the scale and scope of private and public responsibility are not unitary as there is variation in practice based on the separation of ownership and risk-bearing between the public and private sector actors (Figure 1). Because therefore of the variability in the way PPP projects are commissioned, the success of the approach cannot be judged based on its philosophy, but the aggregate success of individual projects.

(please insert Figure 1 here)

2.0 A Critical Review of the Literature and Empirical Evidence on the Role and Implementation of Public-Private Partnerships

The following sections of this paper provide a critical literature review on the role and implementation of PPP schemes. Given the scarcity of reliable empirical evidence in the area of PPP evaluations, our theoretical position, as well as the findings, are far from conclusive. Our limited evidence base draws partly on the theoretical framework of our critical review around critical studies in the area focusing on the evolution and the role of the PPPs in the UK. Our case study is developed from published 'opinion' reports and other documents as well as and primary anecdotal data collected within the hospital, providing a critical underpinning of the actual role of PPs.

The majority of studies reviewed, emphasise that PPPs are established because they can benefit both the public and private sectors by harnessing unique qualities of the public and private sectors and combining them for a better outcome (Santandrea et., 2015; Rosenau, 2000).

Governments find PPPs attractive because by bringing private capital for investment they can release capital for other needs, they expect increased efficiency in the delivery of projects because of its necessary pursuit by the private sector as

means to increase profits and because the agility of private agents may be used to bring reform to sectors through a reallocation of roles, incentives, and accountability.

As Governments face an ever-increasing need to find sufficient financing to develop and maintain the infrastructure required to support growing populations. As most Governments operate deficits budgets, they wish to optimise capital allocation by mobilising private sector capital for infrastructure investment. Structured correctly, a PPP may be able to mobilise previously untapped resources from the local, regional, or international private sector which is seeking investment opportunities.

The goal of the private sector in entering into a PPP is to profit from its capacity and experience in managing businesses (utilities in particular). The private sector seeks compensation for its services through fees for services rendered, resulting in an appropriate return on capital invested.

2.1.PPP as a Tool for Greater Efficiency

The efficient use of scarce public resources is a critical challenge for governments—and one in which many governments fall far short of goals. In the UK, there is a value for money guidance (2013) to "use its resources efficiently, economically and effectively, avoiding waste and extravagance" and a framework on how this can be achieved (2015). This framework introduces the metrics of Benefit-Cost Ratio (BCR) and Net Present Public Value (NPPV) as tools to provide a primary indication of the extent to which a proposal is expected to represent value for money.

Box 1

The BCR is defined as: BCR = Present Value of Benefits Present / Value of Costs Net Present Public Value (NPPV) is defined as: NPPV = Present Value of Benefits – Present Value of Costs

In such evaluations, the PPP approach can argue reduced costs due to increased efficiency compared to the public sector. That sector typically has few or no

incentives for efficiency structured into its organisation and processes and is thus is poorly positioned to build and operate infrastructure efficiently.

In contrast, private sector operators, enter an investment or contracting opportunity with the explicit goal of maximising profits, which are generated, in large part, by increased efficiency in investment and operations. Improving the efficiency of services and operations also increases the chances that those services are economically sustainable and provided at affordable rates even after satisfying the profit requirements of the private operators.

Governments sometimes see PPP as a catalyst to provoke a more extensive discussion of and commitment to a sector reform agenda, of which PPPs are only one component. A key issue is always the restructuring and clarifying of roles within a sector. These roles include service regulator, service provider, and service commissioner. Such re-examination of roles may lead to system redesign based on more efficient principles.

A reform program that includes PPP provides an opportunity to reconsider the assignment of sector roles to remove any potential conflicts and to consider a private entity as a possible sector participant.

3 .PPP IN HEALTHCARE

The latter half of the 1990s witnessed an increasing number of initiatives involving collaboration between the corporate and public sectors to overcome perceived market and public failures of international public health, use global public-private partnerships for health development (Buse and Walt, 2000). The idea was that an approach should be created to enable ad-hoc governmental and multilateral collaborations with individual drug or vaccine candidates to enable a focus on portfolios of products (Widdus and White, 2004). Such portfolios would allow product development PPPs to promote the development of several different candidate products at a given time, which reduced the risk to both the public and private partners. International AIDS Vaccine Initiative (IAVI) in 1996 (Chataway and Smith, 2006) and the Medicines for Malaria Venture in 1999 (Ridley, Gutteridge *et al.*, 1999) are often considered the first examples of this type of portfolio PPP.

Following such disease-specific initiatives and reported success (Ridley 2003, Collins 2004), the argument was made that the PPP model could be expanded from a single portfolio to "providing sustainable health outcomes rather than on the day-to-day interaction that occurs when the government buys a health service from a private supplier or where it leaves the entire matter of health service supply to the private sector" (Nishtar, 2004). By then, the database of the Initiative on Public-Private Partnerships for Health of the Global Forum for Health Research listed 91 international partnership arrangements in the health sector. That number continued to grow under the recommendation for further research on the effectiveness before substantial resources were invested in the expansion of public-private partnership efforts (Barr, 2007).

The objectives of a health PPP partnership depend on the purpose the partnership is designed to serve. This scope may range from product development, improving access to healthcare products, global coordination mechanisms, strengthening health services, public advocacy and education and regulation and quality assurance(Nishtar 2004)

PPPs in healthcare could be classified into four types (Raman and Björkman, 2015) based on their scope and objectives:

(a) *infrastructure* for creating or expanding additional health facilities: Variants of design, build, finance, own, operate, lease, transfer models; joint ventures; private finance initiatives; viability gap funding; land/tax concessions).

(b) *service delivery* for managing and delivering health services: Contracting ("in" and "out"); management contract; co-location; franchising.

(c) *financial protection* by using demand-side financing instruments for pre-purchasing services from private providers: Vouchers/health cards/coupons; insurance; state illness assistance fund.

(d) *other forms of private sector engagement*: Social marketing/health promotion; training, research, capacity building; regulation and governance; networks/alliances, public-private mix; technology enablers (telemedicine).

These models emerge after the private sector performs the following six functions, either alone or in combination.

1. Finance – financing or co-financing of the project
2. Design – design of the project, including the design of the infrastructure and care delivery model
3. Build – construction or renovation of facilities included in the project
4. Maintain – maintenance of hard infrastructure (facilities as well as equipment as applicable)
5. Operate – supply of applicable equipment, IT and management/delivery of non-clinical services
6. Deliver– delivery and management of specified clinical and clinical support services

4.0 A CRITICAL REVIEW OF THE ROLE OF PPP IN THE UK

Public-private partnerships were introduced in Britain in the mid-1990s as one of several procurement initiatives introduced by the United Kingdom Government to address an infrastructure shortfall in that country and commence the procurement reform process identified in Constructing the Team (Latham Report) in 1994 (Latham 1994) and the Report of the Construction Task Force (Egan Report) in 1998 (Egan 1998). This was the first significant policy-based procurement reform to be introduced in developed economies although privately financed and operated infrastructure services were in use at the time of Augustus in Roman times, by the Netherlands and British governments in their colonisation efforts during the 17th and 18th Centuries and the industrial revolution in the 19th Century. Several hybrid forms of private participation in local service provision were widely used by local government in France during the second half of the 20th Century and in the 1990s, build own operate cash-strapped governments widely employed transfer (BOOT) procurement methods in both developing and developed economies as a substitute for state capital to supply essential government services (Regan, Smith *et al*. 2011).

More specifically, PPP started in the UK in 1992, when the government introduced the private finance initiative (PFI). This initiative grew and by 2014 PFI ended accounting for about 10% of all government expenditure on public services

(Roe and Craig 2004) having also been adopted by successive UK governments until doubt about its performance began to gain momentum. A review by the National Audit Office suggested that PFI was proving to be more expensive and less efficient in supporting hospitals, schools, and other public infrastructure than public financing (Comptroller and Auditor General, 2018). At the time of that review, there were over 700 operational PFI deals (128 for healthcare and social care in 2018) with a capital value of around £60 billion and annual charges for these deals amounted to £10.3 billion in 2016-17. Even if no new deals were entered into, future charges which continue until the 2040s would amount to £199 billion.

The PFI schemes progressed despite criticisms which we expound below:

One criticism was that some PFI projects were for accounting purposes, classified as "off-balance-sheet" (in other words, that expenditure on these projects is not included as government spending). This issue enabled the government to deliver public sector projects without affecting its borrowing requirements. It has been suggested that a small number of schemes were said to have gone ahead as PFI projects not because they offered better value for money for the taxpayer, but because of the convenience of PFI in terms of government accounting.

A second criticism was about the benefits from private sector efficiency were less than the benefits from differential costs of borrowing. As the government can borrow money at lower interest rates than private sector companies, and that as private companies need to make a profit, PFI projects must inevitably be more expensive than those undertaken in the public sector. Proponents of PFI needed to show that the greater efficiencies generated in PFI deals outweigh these costs, but this was not clear. One explanation for this could be the lack of extensive retraining necessary for government decision-makers to use advanced project evaluation and measurement methods, including:

- Discounted cash flow analysis
- Risk identification, measurement and valuation
- Lifecycle costing

• Project management
• Incentive-based regulation
• Real options
• Negotiations
• Economic and social impact assessment.

As part of the evaluation of the benefit of the PPP project, the cost of the project being undertaken as a PFI project is compared with the estimated cost of the same project being undertaken by the public sector. This is known as the "Public Sector Comparator" (PSC). The PSC, however, was subjective and has been argued that it was on occasion, been subject to manipulation to ensure that contracts go ahead under PFI rather than the public sector alternative.

A third criticism was that PFI projects could be expensive in terms of the high level of professional fees that are incurred. In some cases, low levels of expertise, a lack of clarity over the desired outcome of a project and poor negotiating skills in the public sector have led to excessive delays in negotiation and poor project management on the part of the public sector.

4.1 PPP in Healthcare in the UK.

The organisation of health care in the UK is based on an institution called the National Health Service (NHS). This institution was based on the idea that health services should be nationally coordinated and free. Specifically, this idea gained increased support in the 1930s and 1940s, and by 1942 a government-commissioned report (Insurance 1942) advocated for family allowances, a free health service and full employment (Abel-Smith 1992). In 1944 the UK Ministry of Health published a White Paper on a National Health Service, which put forward detailed proposals for a system of free universal healthcare funded by central taxation.

In 1945 the new Minister of Health, Aneurin Bevan, was given the task of creating such a system and his National Health Service Act of 1946 (1946) established a structure for the NHS in England and Wales. The new National Health Service was launched as planned on 5 July 1948 and was based on a tripartite system consisting of Hospital services**,** General practitioners and Local authorities. The NHS was the first

Western healthcare system to offer free and universal medical care at the point of delivery.

For the next 40 years, the system continued to evolve structurally and operationally but remained under direct government funding unit 1991. Until 1991 all significant capital expenditure in the NHS was funded by the central government from tax or government borrowing. The NHS did not have to pay interest or repay the capital, so in effect, new equipment and buildings came "free." However, after 1991 hospitals were established as independent business units in the public sector and were required to pay for their use of capital through "capital charges." (Pollock, Shaoul *et al*. 2002).

The seed for this change was planted in the 1980s; the view at the time was that the NHS was a respected but stagnant organisation (Letwin 1993) which had questions over its viability (Illife, 1985) and was ripe for reform along the lines the UK Government had delivered for other sectors of the economy. These reforms included' marketisation' of the public sector (Dorey, 2015)

The intellectual roots of the healthcare market emerged from the work of Alain Enthoven in the early 1980s who noted that flexibility and purchaser power could be increased by 'outsourcing' and independently purchasing traditionally in-house functions (Enthoven, 1980 and Enthoven, 1985). The suggestion was that productive efficiency would more likely be achieved in a situation of competition between providers than in a structure which contains monopoly provision. The added argument that the introduction of the internal market would stimulate staff and professionals to behave in a more responsive manner concerning the needs and that the desires of patients and that patients would be a given a greater choice of the services available were also made in favour of internal markets (Allen, 1995).

The process of introducing a healthcare market in the UK started with the White Paper' Working for Patients' in 1989 which by some has been considered as the watershed of healthcare policymaking for the future of the NHS (Butler, 1992). This paper made provisions (which were realised through the National Health Service and

Community Care Act, 1990) to separate NHS organisations into the roles of 'purchaser' and 'provider' aiming to increase competition through market forces.

Besides, this White Paper was optimistic about the role the private sector could play, citing its competitive tendering exercise for ancillary services as having been a success. The government suggested that there was scope for broader use of competitive tendering beyond non-clinical services, and health authorities were expected to consider private providers as part of their purchasing role.

With the change of UK Government in 1997, the popular market-based vocabulary was also changed along with several features of the healthcare market, such as the concentration on short-term 'spot transactions' (Gray 2011). However, PFI schemes increased despite opposition from the medical establishment who described them by 1999 as "perfidious financial idiocy" (Smith, 1999) and disputed the economic case (Gaffney, Pollock *et al*. 1999). However, by December 2009, 159 PFI hospital contracts were signed in the UK, with NHS England being the biggest procurer in terms of numbers (72%) and capital value of the assets (86%) (Pollock *et al*., 2011). Critical analysis of the PFI scheme suggested that there was no evidence it had increased overall levels of service but in fact, displaced the burden of debt from central Government to NHS trusts and that high cost of PFI schemes had presented NHS trusts with an affordability gap which was met by diverting clinical budgets to fill it (Pollock *et al*., 2011).

The reforms continued with the advent of a new UK Government in 2010, and by 2012, the Social Care Act 2012 was enacted to create even more space for competition. It did this by creating novel commissioning frameworks known as Clinical Commissioning Groups (CCGs)(Asthana, 2011, O'Flynn and Potter, 2011) and by allowing competition for the provision of healthcare between 'any willing provider', including the private sector. This has been referred to as the 'external market' (Owen, 2011). Also, in 2012, the PFI system was reformed and duped PFI-2. PFI-2 introduced some significant reforms to the PFI model, including an overhaul of the equity structure for future projects in the context of the introduction of an 18-month procurement deadline and oversight of all PF2 procurements by the Central Government Unit within the Treasury. Another recommendation was that the range of

services included in PF2 projects would be reduced to provide greater flexibility and efficiency (Buisson, 2013)

With this backdrop, PPPs continued to increase and by 2017 evolved to the idea of developing Accountable Care Organisations (ACO), a form of PPP based on an American model of healthcare. An Accountable Care Organisation (ACO) is a model of healthcare provision where a provider, or group of providers, takes responsibility for the healthcare provision of an entire population. There is no fixed definition of an ACO, but the organisation usually receives an annual, capitated budget to deliver contractually agreed health outcomes, manages the agreements to establish such a system and is accountable for all care (Moberly, 2017). That approach, however, was again resisted and even ended up in High Court unsuccessfully argued as being illegal (Torjesen, 2018). Since 2018 there has not been much momentum in PPP probably as a result of political focus being focused on the exit of the UK from the European Union and managing the COVID-19 pandemic.

The latest data for the state of PPP in the UK was for March 2018 (Treasury, 2018). This is the latest dataset available provided by the UK Government. At the time, for the Department of Health and Social Care, for the Hospitals and Acute Care Sector, they were 109 active programmes with a mean operational period of contracts 32.339 years and SD= 3.835. All these were off-balance-sheet at a capital value of £12.6 billion.

5.0 CASE STUDY- THE PPP PROJECT IN A NHS FOUNDATION TRUST.

Our case is for a PPP project in the market town of Hexham in Northumberland, England. All of hospital under investigation was built under a PFI contract, and the hospital opened its doors to patients in 2003, with the final phase of the £51m development completed in 2008. This hospital was part of Northumbria Healthcare NHS Foundation Trust, and the contract covered all construction and ongoing maintenance.

By 2011, feasibility into transferring the asset back into public ownership was started, and the Trust explored commercial bank and NHS funding but was unsuccessful either because rates were too high or because of central internal NHS

policy. However, the Trust identified through its close relationship with the Local Authority that they could lend the Trust funding, and this represented an opportunity to reduce the cost of the PFI asset and also the potential to generate more comprehensive public sector benefits from greater co-location of services.

In January 2012 the Trust submitted a business case to the Department of Health which identified the case to transfer this PFI scheme (Hexham had a voluntary termination clause) and in August 2012 the Trust received conditional approval (pending number of conditions were met) including a further review by the Treasury. The Department of Health considered the approach of buying out the PFI scheme using local authority funds as "novel, contentious and repercussive". Following receipt of the conditional approval, the Trust set about meeting the various conditions and in the spring of 2013 met with representatives from the Department of Health and the Treasury for a review of the case. Following the review, the Trust received final conditional approval to commence the buyout process in August 2013, if further conditions were met by October/November 2013. This took place, and the annual recurring benefit from the buyout of the PFI scheme was identified at £3.1m per annum for 19 years which was invested directly to patient care.

5.1 Key Findings and Implications

The PPP method of delivering Government projects has been adopted and promoted by subsequent UK Governments for the last 30 years. Throughout that period, the scheme expanded in scope and volume, particularly in healthcare. When looking at the growth of the scheme, it seems that the appetite of UK Governments to push through any opposition, even if spearheaded by world-renown figures of science (Dyer 2018) remains. Although in October 2018, the government announced that it would no longer use the PFI model specifically, it was supporting another PPP model of even broader scope through an Accountable Care Organisation. At the same time, an evaluation of the PFI scheme reported that there is "still a lack of data available on the benefits of private finance procurement" (Controller and Auditor General, 2018).

This does not, however, mean that the use of PPP as a procurement option for Governments should be removed. There are several models of PPP which can be

applied for specific projects, and as such, their success can only be judged based on the individual outputs of the specific project. If a PPP is set up by setting clear objectives, applying the proper procurement processes, selecting the best available deal and ensuring that the deal makes sense (Colman, 2000), then benefits can arise through emergent synergy from the partnership. However, the evidence we reviewed concerning PPP in Healthcare in the UK does not support that this approach was followed and our case example demonstrates how NHS organisations used local resources to correct major Government mistakes.

To secure the best value for money' enablers of success' should be established; these would be for example collecting better data to inform decision-making; ensuring projects have the right skills; establishing effective arrangements to test, challenge and, if necessary, stop projects; and using commercial awareness to obtain better deals (NAO, 2011).

6.0 CONCLUSION

As PFI projects are coming to an end (most PFI contracts expire from 2025 onwards) a unique set of challenges will arise particularly around assets being returned in a satisfactory condition to allow service continuity(Davies, 2020). A new set of skills and capabilities of authorities is required for the expiry process and aspects of the day-to-day management of the contracts relevant for the preparation process. Our view is that the government identifies alternative methods for delivering infrastructure and related facilities services, building on the lessons learnt from PFI, to maximise value for money for the public pound.

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