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The Financialisation of Health in England: Lessons
from the Water Sector

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The Financialisation of Health in England and Wales: Lessons from the Water Sector

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Summary: This is a Foresight paper prepared for the EU-funded research project, Financialisation, Economy, Society and Sustainable Development, FESSUD. Drawing on lessons from the provision of water in England, the paper anticipates future developments in the provision of health, exploring the increasing role of finance and financial cultures. This is captured in the term “financialisation” which has recently emerged in academic literature to account for the rapid expansion of financial assets and financial activity in the economy, and the expanding reach of the financial sector into traditionally non-financial areas of economic and social life.

The paper starts with an overview of the context in which financialisation has evolved within, and impacted upon, the National Health Service (NHS). Two contextual elements stand out. First, since the 1980s, the NHS has been subject to incremental reforms to introduce market-mimetic structures. These reforms accelerated with the introduction of the 2012 Health and Social Care Act (HSCA). This legislation has only just begun to have an impact at the time of writing (December 2015), but the extent of private sector involvement in health provision is likely to increase rapidly as a result of the Act. The second significant aspect of the context for financialisation is the growing financial deficit in the NHS which creates an important backdrop to the HSCA reforms. Irrespective of the proximate as well as the deeper reasons for this, it provides for a narrative of “unaffordability” and “inefficiency”, itself taken as a rationale both for greater private sector intervention and as justification for NHS trusts to increase revenue from private sources. However, the paper

shows that this narrative thread does not fit with global data which indicate that the NHS is broadly in line with OECD averages for spending on GDP, and health outcomes.

The paper considers four mechanisms by which financialisation is affecting the health service in England. First, financing in the sector is allocated on the basis of internal “markets” which mimic financialised structures (regardless of ownership or provision). An institutional division between the “purchaser” and “provider” of health services within the NHS has been refined over the years since it was first introduced in the early 1990s. Health providers are remunerated via a complex “pricing” system known as Payment by Results (PBR) so that transactions between state agencies are delineated in financial terms. Second, financial processes have become embedded in the sector via the process of tendering to both NHS and private service providers. A growing proportion of services has been contracted to private companies, particularly in the wake of the 2012 HSCA. Aside from creeping privatization, this process brings financial practices into the provision of health services, with, for example, health commissioners required to observe competition law even where contracts are awarded to state organisations.

Third, under the 2012 HSCA, the cap on the proportion of income that NHS providers can raise from private patients has increased from 2% to 49%, leading to an increase in private patient income within some NHS hospitals. Global finance is becoming more closely integrated with health provision as a result with new partnerships developing between NHS providers and private investors. Finally, since the early 1990s most new capital investment in the NHS has been undertaken through the Private Finance Initiative (PFI) where the private sector finances the design, build and operation of hospitals and these are then leased back to the NHS Trust over a period of decades. These contracts have proven to be costly for NHS hospitals but highly lucrative for (often institutional financial sector) investors in PFI contracts.

The paper then considers the nature of the private companies that are involved in healthcare. Health providers are often owned by larger conglomerates for which health is one of many assets in a diverse investment portfolio. The paper compares the changes taking place in health with developments in the water sector in England which has been privatized since 1989 and where financial structures, processes motives and investors have long been established. In both sectors, processes associated with financialisation mean that services are increasingly distanced from the materiality of provision and instead are interpreted in terms of the revenue stream that they can provide to investors. Innovative financial practices have been adopted to boost shareholder returns.

In terms of Foresight, health provision is in the process of a fundamental transition from a public service to a financial asset, as has happened in the provision of water in England. The result is expected to be a considerable deepening in the cultures of individualisation and commodification of the health system. This is likely to be associated with a fragmented service and greater inequality in a number of respects: government spending on health will be transferred ultimately to global private finance, boosting the earnings of financial investors; the state will be left with the most difficult (and expensive) to treat as these are of least interest to the private sector; a two-tier system will emerge, with the poorest left with a severely weakened second-rate health system; labour rights are expected to be weakened as employment structures become fragmented across different health providers.

Such developments threaten to undermine the core principles on which the NHS was founded. Furthermore, these changes will be difficult to reverse as the ability of the public sector to pose an effective alternative to private and financialised provision of health will be considerably debilitated.

Key words: Health privatisation, NHS, financialisation

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1 Introduction

This paper is one of a collection of Foresight papers prepared for the EU-funded research project, Financialisation, Economy, Society and Sustainable Development, FESSUD. This paper draws on lessons from an earlier FESSUD case study on the financialisation of water (Bayliss 2014) to anticipate future developments in the National Health Service (NHS) in England. The paper shows that profound changes are taking place in the provision of health, as financial cultures are becoming increasingly embedded in the sector. In part this is through privatisation with a growing proportion of health services contracted to private investors, including through the Private Finance Initiative (PFI), with private health providers often backed by institutional financial investors. But this paper shows that the transitions in the health sector go beyond simple privatisation, with finance now dominating interfaces even between state agents. Furthermore the backdrop of a growing financial deficit in hospital trusts has focused attention on financial performance and legitimises increasing penetration of the private sector in the health system. In common with the provision of water, health services are becoming transformed into financial assets to form part of global investment portfolios of private investors.

The paper draws on the Systems of Provision (SoP) approach adopted in the water paper and applied in a series of case studies on the financialisation of water and housing for Work Package 8 (WP8) of FESSUD. This approach considers that sector outcomes are deemed to emerge from relations between agents which are themselves embedded in historically-evolved social and economic structures and processes. The SoP also derives from the material properties and cultural associations attached to specific goods and services. A key principle of the SoP approach is that consumption is not the spontaneous outcome of decisions made by rational individuals but is inherently linked to the production process. Agents have different, and often competing, interests. Outcomes, and how they are achieved, are highly contested. Contestation among agents leads to continually evolving outcomes which result from the interplay of various factors including

vested interests, bargaining positions and government policy, all of which are embedded in a specific context. Contestation can take the form of formal negotiation, for example, in the rounds of the price-setting process between the regulator and water companies. However, much of the contested space lies outside the realms of the formal regulatory framework. For the SoP approach, what is not regulated might be as important as what is. Furthermore, the regulatory machinery does not just set the rules for the firms involved in the delivery of water or health or housing, but also shapes the ethos of the sector which impacts on all stakeholders. For more information on the SoP approach, see Bayliss, Fine and Robertson (2013).

This paper broadens the scope of the SoP approach to consider the financialisation of the health sector. The aim is to provide an overview of different elements of financing and financialisation to show how they integrate in the health system and to identify the agents involved in provision. One reason for doing this is that the SoP approach developed in WP8 is based in part on the idea that sector outcomes are highly context specific and expanding the sector coverage can allow the significance of context to be explored in more depth. A second reason for following this approach is that these sectors are at different stages in privatisation and financialisation, both of which are well established in water but less so in health. Experiences from other sectors may be instructive in terms of foresight. While the essence of the SoP approach is that the system in its entirety needs to be reviewed to understand the way in which agents interact to reach outcomes, some aspects of health provision, for example, primary care, have been omitted in this paper to make the task manageable.

This paper adopts a broad interpretation of financialisation, in line with that proposed by Epstein (2005, p. 3) as “the increasing role of financial motives, markets, actors and institutions in the operation of the domestic and international economies”.¹ Recent

¹ In our work for WP8, we developed a more precise definition of financialisation (see Deliverable D8.27), making the distinction between commodification of production, commodity form where payments are made on a periodic basis (although not necessarily attached to profit oriented activity, such as a nominal payment for a service) and commodity calculation where financial calculation is made but monetary exchange does

changes in internal structures in health provision as well as new legislation have brought in a more finance-oriented ethos, and privatisation is expected to expand greatly in the future. As such, then, the Epstein definition is appropriate here as the sector shows a clear shift towards greater financial pressures and narratives, but largely within a state-owned framework of provision at this stage. However, this varies and some areas of healthcare have had more financialisation activity than others, as the paper demonstrates. The paper is organised as follows. The next section sets out the main findings from the case study into the SoP for water in England and Wales in summary form by way of brief background. This is followed by an outline of the history and key issues that frame the context for the health SoP in England. As mentioned above, there are different facets to financialisation and the nature and impact vary according to the location within the SoP. Section 4 presents four core mechanisms by which financialisation is having an impact on the health service: internal “markets” create financialised structures (regardless of ownership); outsourcing and subcontracting of NHS-funded services to non-NHS (mainly private) service providers; private patient income for NHS providers; and the private finance initiative (PFI). Each of these has contributed to increasing financialisation although the incidence and impact on processes and outcomes are diverse. This is followed by a section on the private companies that are involved in healthcare with particular emphasis on the role of those owned by private financial sector investors. The final section concludes with a comparison of health and water provision and draws some conclusions for foresight.

2 Water in England and Wales

The SoP for water in England and Wales was the subject of a detailed case study for FESSUD (Bayliss 2014). There was a great deal learned from this study and too much to be

not necessarily take place (see Bayliss, Fine and Robertson 2015). In due course, there may be scope to apply this framing to developments in the health sector but, at this stage, with a focus on foresight and general trends in the sector, a broader definition suffices.

repeated here but some of the salient points that are relevant to the provision of health are outlined below:

- The sector has evolved considerably since it was privatised by listing on the London Stock Exchange (LSE) in 1989. Initially owned by dispersed shareholders, including water company customers, now the majority of firms have been de-listed and, since the mid-2000s, there has been greater entry of private financial owners in the sector. Four out of the ten water and sewerage companies (WASCs) are now owned by special purpose vehicles (SPVs) set up by financial investors, mostly in offshore locations.
- The material features of water have shaped the way that finance has impacted on the sector. Water is largely homogenous. Bills are paid regularly, demand is stable, technology does not change rapidly and this means that the associated revenues are predictable far into the future. This has created a source of funds which can be securitised with the cash flow from future water bills packaged and sold as financial assets.
- The context of England and Wales has also proved to be conducive to financialisation. The sector regulator, Ofwat, is required to ensure that firms are able to finance their operations. The Government has stated its commitment to increasing private financing for infrastructure, and places considerable importance on an attractive regulatory environment for investors. The regulatory structure has been stable and predictable for the past fifteen years and prices have allowed generous returns for shareholders although, in 2015, tighter price controls were imposed on private water companies.
- The nature and extent of financialisation varies according to ownership structure. Four water and sewerage companies owned by private financial investors have carried out a specific kind of financial process known as Whole Business Securitisation (WBS) which has enabled them to develop highly leveraged corporate

structures. The debts accrued are used in part to finance investment but are also used to buy the companies themselves and to pay dividends. High debts (in some cases owed to group companies) are financed with interest payments that are tax deductible. These water companies keep their tax liabilities low and financing costs are passed on to consumers.

- The sector regulator, Ofwat, sets prices and monitors firms' performance. However regulatory interventions are not neutral and decisions are contested, although contestation is largely between the regulator and water companies with little involvement from consumers or labour. The regulator intervenes selectively, for example, setting and monitoring targets for customer services while stepping back from intervening in highly leveraged corporate structures or high payments of interest and dividends.

This then provides a brief outline of the SoP for water in England and Wales. There is far more detail in the case study paper but these are the significant issues that have resonance with the SoP for health discussed in the rest of this paper.

3 The health system in England

The National Health Service (NHS) was set up in 1948 bringing all medical services together (hospitals, doctors, nurses, pharmacists, opticians and dentists) in one umbrella organisation to provide services that are free for all at the point of delivery.² There were three central principles:

- That it meets the needs of everyone
- That it be free at the point of delivery

² Some charges were introduced soon after the NHS was established. A prescription charge of one shilling (5p) and a flat rate of £1 for ordinary dental treatment were brought in on 1 June 1952, although prescription charges were abolished in 1965 but reintroduced in 1968 <http://www.nhs.uk/NHSEngland/thenhs/nhshistory/Pages/NHShistory1948.aspx> [accessed 23 December 2015]

- That it be based on clinical need and not ability to pay.

This has since been expanded to cover seven principles as set out in the 2011 NHS Constitution (NHS 2015).

1. The NHS provides a comprehensive service available to all;
2. Access to NHS services is based on clinical need not an individual's ability to pay;
3. The NHS aspires to the highest standards of excellence and professionalism;
4. The patient will be at the heart of everything the NHS does;
5. The NHS works across organisational boundaries and in partnership with other organisation in the interests of patients, local communities and the wider population;
6. The NHS is committed to providing best value for taxpayers' money and the most effective fair and sustainable use of finite resources;
7. The NHS is accountable to the public, communities and patients that it serves.

The NHS accounts for the vast majority of healthcare spending in the UK. Private spending on health in 2012 made up only about 16% of total UK health spending.³ Together with 2010 this was the lowest proportion since records began in 1997. Private spending increased steadily by 5.1% a year in the decade before the 2008 downturn but fell by an average of 2.8% a year in real terms between 2008 and 2012, affected by the financial crisis (Charlesworth 2015; Lloyd 2015). The majority of those with private health cover receive it as an employee benefit. In the 2000s, private firms saw a fall in demand for privately-funded treatment and an increase in demand from the NHS to deliver the same operations (Arora et al 2013).

For around forty years after it was established, the operation of the NHS continued relatively unchanged but since 1991, the NHS has been subject to what has been termed an "unrelenting sequence of reorganisations, all attempting to recalibrate the internal

³ This includes goods such as over-the-counter pharmaceuticals and services such as dental and private hospital services.

market” (NEF 2014, p.9). The most recent reform came with the 2012 Health and Social Care Act (HSCA), which introduced some dramatic changes, particularly in the reach of the private sector. Before the 2012 HSCA, an internal market was already in existence in health provision (discussed below) with a division between purchasers and providers of healthcare. However, until 2013, the providers of care were almost all part of the public NHS (hospital or community NHS trusts). Under the terms of the HSCA, the “commissioners” of healthcare, responsible for around 60% of the NHS budget, are now required to allocate funds by means of a competitive tender with all providers, including for-profit health companies as well as NHS providers, all treated equally with “any qualified provider” entitled to bid (unless there is justification for not doing so).

The sector regulator, Monitor, was also established under the HSCA 2012 (p.91). Under Section 62:

“(1) The main duty of Monitor is to protect and promote the interests of people who use health care services by promoting provision of a health care service which:

(a) is economic, efficient and effective, and

(b) maintains or improves the quality of the services”.

Clearly, the mandate of Monitor is fairly broad. There is also a requirement to ensure that competition rules are observed. This brings health provision into closer contact with financial practices. In the short time since it was established in 2012, Monitor has evolved considerably. Initially set up with fewer than 50 employees, there has since been an increase in staff to more than 350. Recruitment has added economists, accountants, communication specialists, policy experts and competition lawyers.⁴

The vision associated with the HSCA is of a regulated health service like those that have been established with the privatised utilities in England. The NEF (2014, p.5) quotes David Bennett, Chief Executive of the regulator, Monitor:

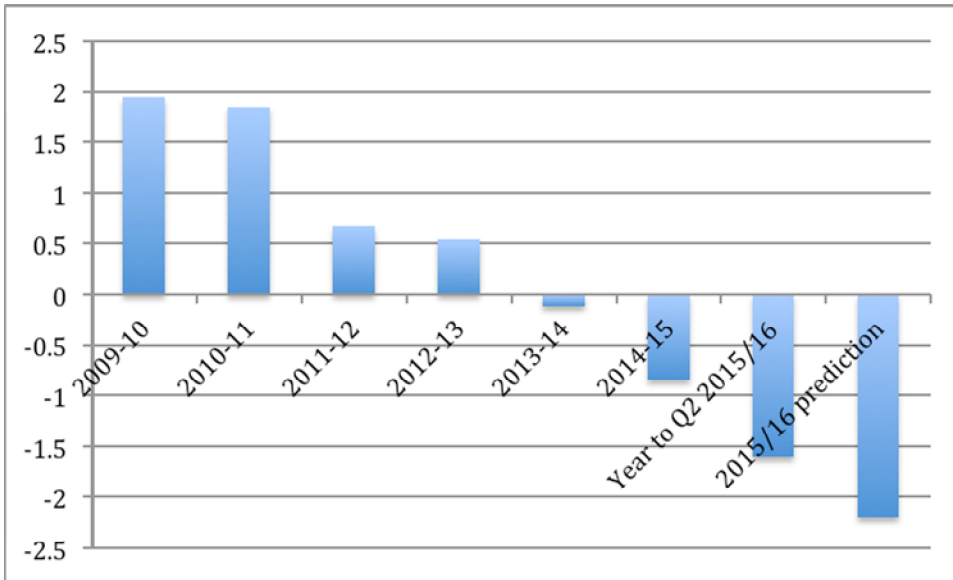
⁴ “Getting to grips with Monitor’s framework for change” Health Service Journal, 20 July 2015.

We, in the UK, have done this in other sectors before. We did it in gas, we did it in power, we did it in telecoms [...] We've done it in rail, we've done it in water, so there's actually 20 years of experience in taking monopolistic, monolithic markets and providers and exposing them to economic regulation.

At the time of writing (December 2015), the NHS is facing a growing financial crisis. The number of NHS providers (acute and specialist hospitals, community organisations and mental health trusts) reporting a deficit doubled between 2012/13 and 2013/14. At the end of the 2014/15 financial year, 131 NHS Trusts reported an underlying financial deficit while 115 delivered an underlying financial surplus. However, the combined total of the deficits significantly outweighed that of the surpluses so that the net deficit of health providers came to £842m in March 2015 (DoH 2015). Based on current performance, NHS England's Trusts are predicting they will end the 2015/16 financial year with a deficit of £2.2bn. Figure 1 shows how the financial position has changed since 2010 when Trusts reported a surplus of nearly £2bn. Deficits are concentrated in the acute (hospital) sector. At the end of September 2014, 81% of all NHS acute hospitals in England were in deficit (Charlesworth 2015). There are concerns that all of England's 156 acute hospital trusts will be in the red at the end of 2015-16.⁵

⁵ "NHS cannot make £22bn cut sought by government, finance chiefs warn" The Guardian, 18 November 2015.

Figure 1: Net surplus/deficit of NHS providers in England (£bn at 2015/16 prices)



Sources: 2009-2015, Department of Health Annual Accounts, also in The Independent 9 October 2015 “The financial meltdown of the NHS, in one chart”; predictions 2015-16, The Guardian, 20 November 2015, “NHS deficit soars to £1.6bn”

In August 2015, the Chief Executive of Monitor sent a letter to all Foundation Trusts (FTs) in deficit saying that the NHS is “facing an almost unprecedented financial challenge this year”, adding that no stones must be left unturned in their “collective efforts to make the money go as far as possible” and this includes reviewing staffing to make sure “only essential” vacancies are filled.⁶ Some Trust chief executives have responded that they cannot improve their financial position without a significant compromise to access standards, service provision and quality of care.⁷

Reasons put forward to account for the deficit include:

1. **Increasing and ageing population:** The number of people aged over 65 is estimated to increase by 51% between 2010 and 2030 and the number over 85 will

⁶ “FTs should scrap ‘non-essential’ jobs due to unprecedented financial crisis” National Health Executive 4 August 2015

⁷ <http://www.lgcplus.com/news/no-more-savings-can-be-made-hospitals-tell-regulators/5089955.article>

double over the same period. Conventional wisdom is that this will lead to greater demands on the health service. However this may just tend to delay the time at which the health care costs associated with later life are incurred, rather than increasing those costs per se (Appleby 2013).

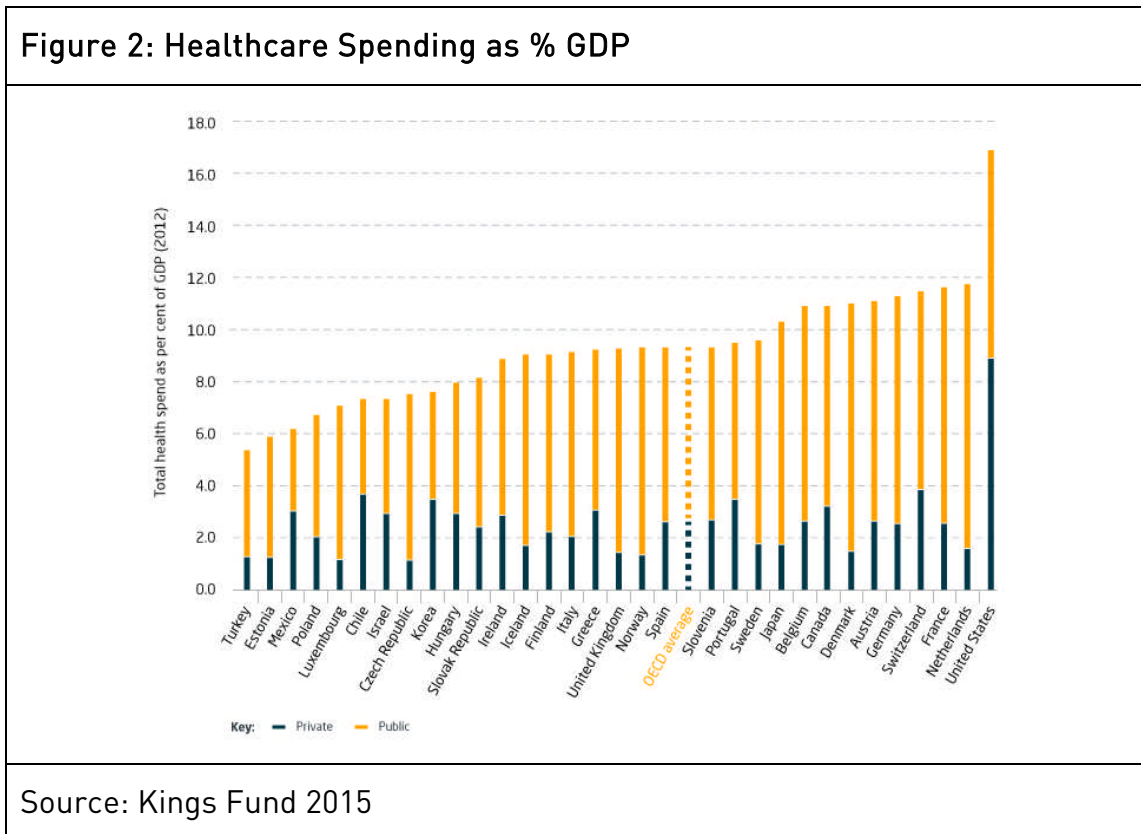
2. **Increased staff costs:** There are two upward pressures on staff costs. In response to concerns about the quality of care following a scandal at Mid Staffordshire and subsequent review, new NICE guidance on safe staffing levels were drawn up as well as a requirement to publish ward staffing levels. In 2011/12 and 2012/13 the number of nurses employed by the NHS fell, but in 2013/14 the overall number of nurses increased by 1%, with acute, elderly and general nurses increasing by 2% in that year alone. In addition to the requirement to increase staffing numbers, the NHS has struggled to recruit permanent skilled staff (in part due to a pay freeze imposed to keep costs down). The result has been a large increase in the cost of temporary staff. Spending on this has grown sharply from £3.6bn in 2012/13 (around 7 percent of all NHS staff costs (Nuffield Trust 2015)) to £4.6bn in 2013/14 (2014/15 prices) – a 28% increase in just one year (Charlesworth 2015).
3. **Underfunding of social care:** Public spending on social care and personal adult social services has fallen (Lloyd 2015). Research cited in The Guardian indicates that some 500,000 people who would have received social care in 2009 no longer qualify for it, despite an ageing population.⁸ Nine out of ten General Practitioners (GPs) are reported to believe that deep cuts to social care under the 2010-2015 coalition government have added to the growing overcrowding at GP surgeries and hospital A&E units. One knock-on effect of the failings in social care provision has been an increase in 'delayed discharges' meaning that patients spend longer in hospital than is medically required (Gaughan et al 2014).

⁸ "'Chronic underfunding' of social care increases burden on NHS, say GPs" The Guardian 13 March 2015

4. **Inadequate funding:** Since it was founded in 1948 government spending on health across the UK has risen by an average of 3.7% a year in real terms (to 2014) and has more than doubled as a share of GDP, from 3.6% in 1949/50 to 7.5% in 2013/14 (Charlesworth 2015; Lloyd 2015) but there has been variation in health spending over the years. The 2001/02 to 2004/05 parliament saw the highest period of spending growth for the UK NHS at 8.7% a year in real terms (Charlesworth 2015; Lloyd 2015). This means that in 2010 the Conservative/Liberal Democrat coalition government entered power after the longest period of sustained NHS spending increases in its history. Waiting times were the lowest they had ever been. International surveys of health systems put the NHS high in the league tables on many measures and public satisfaction was at its highest ever (Timmins 2012). In contrast, the coalition government (2010 to 2015) oversaw the lowest rate of growth in health spending since 1955 at 0.6% per annum (Charlesworth 2015; Lloyd 2015).

While the NHS budget has been increasing by a small amount in real terms over the past five years, rising demand means that costs need to be cut to maintain the current level of services. Funding allocations to health providers are based on trusts improving efficiency. Many spending cuts have already been made and it is increasingly difficult to cut further. Hospital trusts managed to withstand financial pressures, at first using traditional measures (pay freezes, cuts in management costs, reductions in tariffs for some services) but the strain is increasing. There is reportedly no more room to cut costs. Now some large NHS organisations, which have historically been considered to be financially stable and effective at managing their resources, are in deficit (Nuffield Trust 2014b). This approach to increasing efficiency is reported to have created a short-term focus. As the Health Select Committee has commented in several reports, the NHS has been over-reliant on the one-off effects of pay restraint and administrative cost savings and on reductions in the tariff payments to hospitals for the care they provide. Progress on more fundamental change has been slower than planned (Charlesworth 2015).

While there is considerable media attention devoted to the health service being in crisis, a review of the UK in international context shows that spending is about average. Figure 2 shows healthcare spending as a percentage of GDP for selected OECD countries.



The UK is not far from the OECD average with about 9% of GDP spent on health, although the proportion of private spending on healthcare in the UK is below average at 1.5% of GDP compared with an OECD average of 2.6%. Note that the USA is something of an outlier with much higher spending per capita and that this is not just from private finance. Even with high levels of private spending, public spending per capita in the USA is higher than in some other OECD countries.

Figure 3: Life expectancy and health care spending: OECD countries (2008)

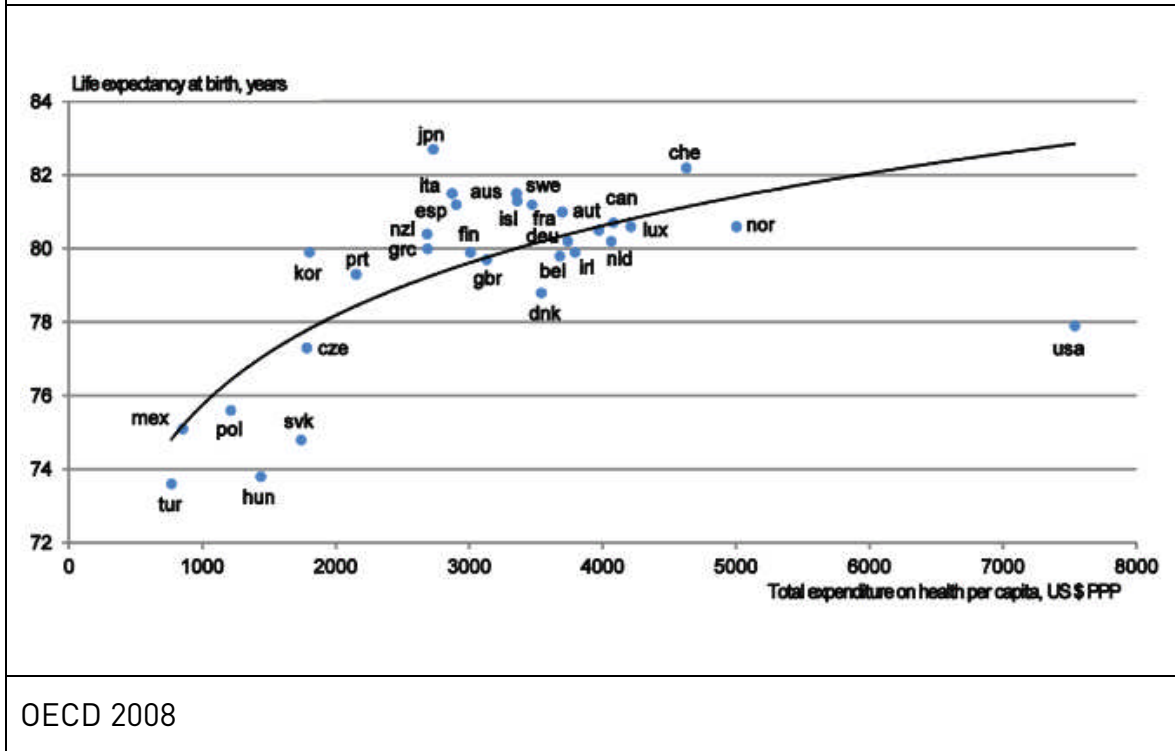


Figure 3 shows that greater expenditure on health per capita is associated with longer life expectancy. GBR is roughly in the middle of OECD countries on these scales. The USA is again an outlier here with much higher spending and lower health outcomes in terms of life expectancy.

This, then, sets the context for financialisation in England. The sector is under financial pressure with a narrative that universal healthcare is “unaffordable” and reforms have been recently introduced focusing on privatisation and competition with a view to making the sector more efficient. However, the performance of the sector is in line with average OECD spending and performance. The extreme challenges currently facing the sector have only emerged since the last parliament and are largely due to the tighter budgets from central government. Yet this “crisis” looks set to bring about a radical transformation in the system of provision of healthcare in England.

4 From neoliberalisation to financialisation of the health system

The health sector is large and diverse. To properly understand the on-going processes requires a system-wide review of the sector. Sector reforms are generating shifts in social relations that need to be set in the wider context. This section considers the current and potential ways that neoliberal policies in health are opening pathways for more financialised structures in the provision of health. This section draws largely on Epstein's broader definition of financialisation as financial motives and practices have become increasingly central to the way that the sector is organised. Four key "mechanisms" of financialisation prevail in the NHS in England.⁹ While these are interlinked, each has different implications for financialisation in the sector.

4.1 Internal "markets" and financial structures

Since the early 1990s, incremental reforms to the NHS have focused attention on finance, with a price put on health treatments, even though providers were mostly state agents. The 1991 NHS and Community Care Act introduced the "purchaser-provider split". The aim was to apply market principles in order to drive down costs and improve quality. Services were commissioned by District Health Authorities as well as groups of fund-holding GPs. At the same time, some hospitals and other providers such as mental health services were established as separate legal entities as NHS trusts (NEF 2014).

This "purchaser-provider" principle has been refined over the years and was adjusted further with the HSCA in 2012. The "purchasers" or commissioners of care now consist of 209 Clinical Commissioning Groups (CCGs) described as "clinically led statutory NHS bodies made up of GP practices from the local area" (NHS Clinical Commissioners

⁹ Since 2013 the four countries of the UK have had separate health systems. Most of the following discussion relates to NHS England.

website).¹⁰ CCGs were established in April 2013 and took over from Primary Care Trusts (PCTs). CCGs are responsible for about 60% of the NHS budget.

The “providers” of care are the NHS hospital and mental health and community trusts, private providers, not for profit enterprises and social enterprises. There are currently 247 NHS organisations responsible for delivering and managing hospital and community nursing care, ambulance and mental health services. NHS providers can be foundation trusts (FTs) or NHS trusts (Lafond et al 2015).

From 2003, all NHS trusts could apply to become FTs. This meant that they would become independent of the NHS, set up as public benefit corporations with an independent board of directors. There are 152 FTs. They provide over half of all NHS hospital, mental health and ambulance services. FTs have autonomy over decision-making and can decide, with their governors and members, their own strategy and the way services are run. They can borrow money, retain surpluses and decide on how to provide services.¹¹ Under the HSCA, the aim was for all hospital trusts to be FTs by 2014, although that has not been achieved (NEF 2014).

The sector has three main regulatory agencies. Care standards are regulated by the Care Quality Commission (CQC). NHS trusts (that are not FTs) are regulated by the NHS Trust Development Authority (TDA), and Monitor oversees the financial and management performance of FTs. One of the core activities of Monitor is the monitoring of the payment system for FTs. Health providers are remunerated under a system known as “payment by results” (PBR) which was introduced in 2004 to replace block contracts for hospital funding. Under PBR, prices are fixed nationally for specific procedures.¹² This does not cover funds allocated to GPs, pharmacists, dentists and other providers of primary care (Nuffield Trust 2014a). PBR covers the majority of acute healthcare in hospitals, and there

¹⁰ <http://www.nhscc.org/ccgs/>

¹¹ <https://www.gov.uk/government/publications/nhs-foundation-trust-directory/nhs-foundation-trust-directory#what-the-ratings-mean>

¹² This is an important part of the legislation under the HSCA - organisations do not compete for contracts on the basis of price. Even the strongest supporters of marketization are aware that this may lead to quality concerns.

are national tariffs for admitted patient care, outpatient attendances, accident and emergency and some outpatient procedures. While PBR is widely used in acute hospitals, secondary care in mental and community health services continues to be financed with block budgets (90% of community services and two-thirds of mental health care) (Nuffield Trust 2012b).

Under PBR, prices are fixed for specific procedures. This is based on the diagnosis related group (DRG) system used in the USA and elsewhere. PBR was introduced at the same time as commissioning in the mid-2000s to support patient choice of provider to allow private providers to compete for the provision of some elective contracts (Nuffield Trust 2014, and see below). The objectives of PBR are, according to the Department of Health (DoH 2012, p.9):

- To support patient choice so that the money can follow the patient to different types of provider;
- To reward efficiency and quality by allowing providers to keep the difference if they can provide the required standard of care at a lower cost than the average price;
- To reduce waiting times by paying providers for the volume of work done;
- To refocus discussions between commissioner and provider away from price towards quality and innovation.

In practice, PBR is extremely complex. The PBR system starts with a clinician making notes on the patient record and ends with the commissioner making a payment to the patient's health provider. There are numerous factors to be taken into account. For example, the tariff for admitted patient care is set at "spell level" and a spell is the period from admission to discharge within a single provider for a single patient. Whilst admitted, a patient might see more than one consultant during a spell of care. These are called "finished consultant episodes" (FCEs). The vast majority of patient spells have only one

FCE. Some have two and a small number may have more. The distinction between spell and FCE is important in the PBR process (DoH 2012).

There are around 26,000 codes used in the PBR process to describe specific diagnoses and interventions (DoH 2012). To make the system more manageable, these are grouped into Healthcare Resource Groups (HRGs) described as “standard groupings of clinically similar treatments which use common levels of healthcare resource”¹³ and this grouping process “allows tariffs to be set at a sensible and workable level” (DoH 2012). HRGs are nationally determined “units of currencies” which are the unit of healthcare for which a payment is made and includes different time periods from an outpatient visit to a stay in hospital to a year of care.¹⁴ HRGs are derived from diagnosis and procedure and they are intended to allow comparison of activity within and between different organisations. The classification system is designed and refined by the National Casemix Office (NCO) using the Casemix Grouper Software (NCO 2015). In 2014 there were more than 1,300 HRGs included in the national tariff (Nuffield Trust 2014b), and the number has increased substantially since 2003 (Nuffield Trust 2014a).

The introduction of PBR is associated with a statistically significant increase in the number of planned and emergency admissions, a reduction in the length of hospital stay and an increase in the proportion of day cases across most groups of patient providers and HRGs. There has been no evidence of a reduction in quality of care. This is consistent with studies across Europe into similar DRG-based payment systems in replacing block budgets (Nuffield Trust 2014a; 2014b). However, providers may have an incentive to diagnose and treat patients to maximise their income: “there are incentives to over-treat: a phenomenon familiar in the USA and other health-case systems based on payment by results (more accurately defined as payment by activity since money flows irrespective of outcomes)”, cited in (NEF 2014 p.39).

¹³ “Introduction to Healthcare Resource Groups” www.hscic.gov.uk/hrg

¹⁴ “Introduction to Healthcare Resource Groups” www.hscic.gov.uk/hrg

The pricing schemes are highly complex and costly to administer. The system relies on the quality of information provided on cost data as the basis for reimbursement, and there is evidence of a wide range of practice in the way in which costs are allocated (Nuffield Trust 2014b). Overall, the evidence indicates that “case mix adjusted payment systems” might lead to improvements in productivity and efficiency of providers of care and make the individual procedures more cost efficient, but there is no clear evidence that the health system as a whole is more efficient. PBR is intended to incentivise hospital activity but there are suggestions that it might be better to focus on more collaborative approaches to health (NHSCC 2014).

Tariffs are traditionally supposed to be based on the average actual cost of services reported by the NHS but in practice various adjustments are made. Changes in 2010/11 brought in “best practice” tariffs so that pricing is based on best clinical practice rather than average cost (Nuffield Trust 2014b). In addition the tariff received by the provider is multiplied by a nationally determined “market forces factor” (MFF) which is unique to each provider and reflects that it is more expensive to provide services in some parts of the country than in others and there may be other adjustments to the tariff with regard to length of stay in hospital and specialised services or “to support particular policy goals” (DoH 2012, p.8).

In the current financial climate of fiscal austerity, PBR is used as a policy tool to push acute hospitals to cut costs (Nuffield Trust 2014b). One of the reasons for the financial deficit of the NHS is funding cuts (see above) and these are being achieved through the PBR. Since 2011 the prices paid under PBR have fallen as part of the DoH's strategy to deliver efficiency savings of £15bn to £20bn in the five years to 2015. In 2010/11 the annual uplift in prices was set at zero when the inflationary impact of hospital pay and prices was expected to run at about 3.5%.

Prices are a growing source of tension in the NHS. In what was described as an “unprecedented development” in January 2015, healthcare providers rejected the

controversial 2015/16 tariff proposals.¹⁵ The main area of disagreement was the level of payment to NHS providers for emergency admissions which had been set in 2010/11 at 30% of the regular tariff price. This pricing strategy effectively applied a financial penalty to hospital emergency admissions in order to provide an incentive to reduce such admissions (NHS Confederation 2015). Prices in the health sector, then, may be based on cost but they are also a means of policy intervention.

With hospitals operating as independent financial entities they run the risk of financial failure which has a significant impact on health services. In 2013 the South London Healthcare NHS Trust (SLHNSHT) became the first to be put into administration because of poor financial performance as well as issues with care quality. The administrator of SLHNSHT indicated that private healthcare firms may end up managing parts of the Trust or delivering some of its services.¹⁶ Part of the financial difficulties facing the Trust stemmed from payments to the private sector for PFI contracts (see below). In its last year of operation (2012/13), the Trust paid £27.2m in finance costs equivalent to about 6% of operating costs. The trust had six PFI contracts and spent 16% of its income on all of its PFI contracts (NHS 2013).

The internal market in the NHS has created a financialised structure even in interactions between state agencies. Financial penalties are applied by the state to incentivise specific practices. But these are state agents and providers have no monetary gain from the financial performance of the trust. This is a system which treats NHS providers as private profit makers and the result is often simply to reduce funding for services. The process of creating a market for healthcare has proven to be complex and expensive. As with water, tariff setting is subject to contestation in health even though the majority of the agents involved are in the state sector. Even where financial transactions are between state agents, there are now strict financial constraints as the experience of SLHNSHT

¹⁵ "'Disarray' as providers resoundingly reject 2015/16 tariff proposals" National Health Executive 29 January 2015.

¹⁶ "Eleven NHS foundation trusts have serious financial problems, MPs told" The Guardian, 18 September 2012

demonstrates. While internal markets have so far been a matter of transactions largely between state agents, creating a “market” structure with independent “buyers” and “sellers” sets the stage for increasing the scope for bringing in other non-NHS providers as the next section indicates.

4.2 NHS funding for non-NHS providers

The contracting of private services has long existed in the NHS. The Thatcher Government of the 1980s introduced outsourcing of some non-clinical activities. The 2000s saw an increase in the volume of procedures carried out by the private sector using NHS funding. In 2000 the Labour government set up a “concordat” to allow privately-owned centres to be contracted by the NHS to perform low risk common elective surgery and diagnostic tests such as cataracts and hip replacements to reduce waiting times (NEF 2014). With the introduction of “choice”, patients were allowed to choose the hospital they attended for some surgical procedures. Independent Sector Treatment Centres (ISTCs) were introduced in private hospitals to provide routine treatments in order to increase choice and to clear waiting lists (Arora 2013). From 2006 onwards the role of non-NHS providers increased markedly. In the decade from 2003, £5bn of NHS resources were transferred through ISTCs to for-profit companies such as Ramsay Health Care UK, Netcare and Virgin Health (NEF 2014). NHS England’s spending on privately funded healthcare services has more than quadrupled in real terms and, in 2011/12, nearly 20% of NHS expenditure on hip and knee replacements was with private hospitals and clinics. This is in contrast with the policy in Scotland and Wales where healthcare spending is channelled mainly to NHS providers unless there are exceptional circumstances (CMA 2014).

The main area of spending on non-NHS providers has been in community and mental health services. Between 2010/11 and 2012/13, PCT expenditure on NHS-provided community services fell while spending on care provided by non-NHS providers increased rapidly. One pound in every five spent by PCTs on community health services in 2012/13

was spent on care provided by independent sector providers, an increase of 34 per cent in one year alone. Similarly, funding for independent sector mental health service providers increased by 15 per cent in real terms between 2011/12 and 2012/13 alone, while funding for NHS-provided mental health services decreased by 1 per cent (Nuffield Trust 2014). Table 1 shows that between 2010 and 2013 around 18% of community health spending by PCTs was through private providers. For hospital services the proportion has stayed relatively constant at just 3.6% (Nuffield Trust 2014).

Table 1: Proportion of PCT spending going to independent sector providers (% total PCT spending)			
	Community Health	Mental Health	Hospital Services
2010/11	12	12	3.2
2011/12	14	12	3.7
2012/13	18	13	3.6

Source: Nuffield Trust 2014

For the past five years, private provision of NHS services has been relatively small but this is expected to change rapidly in the wake of the 2012 HSCA. Evidence cited in The Guardian indicates that in 2014 private firms won £3.54bn of £9.628bn worth of deals awarded in England – a win rate of 36.8%.¹⁷ According to the British Medical Journal (BMJ), private sector providers secured a third of the contracts to provide NHS clinical services that were awarded in England after the HSCA came into force in April 2013. Analysis of 3494 contracts awarded between April 2013 and August 2014 (disclosed under

¹⁷ "Far more NHS contracts going to private firms than ministers admit, figure show" The Guardian, 25 April 2015.

requests made under freedom of information legislation) showed that in total non-NHS providers (including private sector, voluntary sector and other providers) have secured 45% of contracts awarded since April 2013, 1149 contracts (33% of total) were to private sector providers, 335 (10%) to voluntary and social enterprise and 100 (3%) to other types of provider such as joint ventures and local authorities. 1910 (55%) of contracts were to NHS providers (including NHS hospitals, community and mental health providers and general practices (BMJ 2014). Some large contracts are now being awarded to private firms. Of 13 contracts awarded in 2013 worth more than £100m, six went to private firms, five to private consortia and just two to NHS providers.¹⁸

There are expectations that the new legislation will bring in rapid changes in health provision. Evidence presented by the Centre for Health and the Public Interest shows that the government introduced similar policies in social care provision in the 1990s and 2000s. Under these reforms, local authorities were required to purchase care services from the independent sector. The result was a rapid growth in private provision of state-funded social care services. Similarly, funding to local authorities was restricted at a time of increased need, forcing governments to generate “efficiencies” and a reduction in quality was the result (CHPI 2013).

An increase in the proportion of privately provided, NHS-funded healthcare is likely to have a wider impact on overall service provision and raises inherent contradictions in the policy. First, there is evidence of cherry picking. Private providers opt to treat the most straightforward cases to maximise profits leaving the state with the most difficult to serve. Medical markets are heterogeneous because all patients are different. But private operators can benefit from market segmentation, offering commercially rewarding treatments and only treating the easiest patients (Woolhandler and Himmelstein 2007). Recent contracts have failed to be awarded where anticipated profitability is too low. In

¹⁸ “Far more NHS contracts going to private firms than ministers admit, figures show” The Guardian, 25 April 2015.

June 2015, private companies failed to bid for a £687m contract to provide cancer care for patients in Staffordshire because of the contract price.¹⁹

Second, the system itself is costly to administer. One estimate from the National Audit Office (NAO) cited in NEF (2014 p.41) put the costs of implementing the HSCA at between £2bn and £3bn. NEF cites further research that states that the old NHS block budget system was relatively inexpensive to manage and administer. The purchaser-provider split with private finance and national tariffs requires far more information and monitoring which inevitably lead to higher transactions costs.

Third, there is little compelling evidence that competition for health providers leads to better health outcomes (NEF 2014). Seriously ill people who are the major consumers of health are not able to shop around, reduce their demand if suppliers raise their prices or to accurately appraise quality. Evidence from the USA consistently finds that public funding of private care yields poor results. Competition between public and private means that private firms carve out profitable niches leaving a financially depleted public sector responsible for unprofitable patients and service. Furthermore, "Matrices intended to link payment to results instead reward entrepreneurs skilled in clever circumvention" (Woolhandler and Himmelstein 2007, p.1129).

Finally, the process of competitive tendering required under the HSCA is to be carried out by commissioners who are selected for their clinical expertise, but often inexperienced in implementing and monitoring private sector contracts. The 2012 Act brings CCGs, that are mainly comprised of GPs and other clinicians such as nurses and consultants,²⁰ into the realm of contract and competition law. Under the HSCA, CCGs are required to promote the rights of patients to make choices with respect to treatment and they are required not to "engage in anti-competitive behaviour". In selecting a provider the main procurement routes open to the CCG are (NHS 2012):

¹⁹ "Private sector backs away from £687m NHS cancer deal" Financial Times 5 June 2015.

²⁰ <http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx>

- To open the service to AQP [Any Qualified Provider] and enable patients to choose from these providers;
- Competitive tendering to appoint a specific provider, a specified number of providers or collaboration of providers; or
- Appoint a specific provider or group of providers without competition (Single Tender Action).

However, this last action is discouraged for the reason that: “The law in this regard is complex and carries an inherent risk of challenge”. Even if there is reason to follow the single tender option, it is regarded as good practice to put it out to tender so that there is transparency with the selection of the provider (NHS 2012).

Thus, although CCGs are not always required to put services out to tender, they are advised to do so by the NHS in order to protect themselves from legal challenges from private providers. And such challenges are starting to emerge. The CEO of private company, Ramsay Healthcare, has complained that CCGs in some parts of England are urging GPs to refer patients to NHS hospitals rather than private providers, against the terms of the HSCA which says commissioners are not allowed to discriminate against certain types of providers. CCGs are reported to be doing this in an attempt to keep their local trusts viable.²¹ Similarly, private company, Spire, has filed a complaint with Monitor that the number of patients being referred to its Fylde Coast Hospital had fallen as a result of actions by the CCGs which had the effect of directing patients away from Spire’s hospital and towards Blackpool Teaching Hospitals NHS Foundation Trust (Monitor 2015). In August 2015, Monitor announced it was launching an investigation into the process by which Barking and Dagenham and Redbridge, Havering and Waltham Forest CCGs awarded a care contract to Barking, Havering and Redbridge University Hospitals NHS Trust following a complaint by Care UK.²²

²¹ “CCGs ‘urging GPs to refer to NHS trusts’ against competition law” Pulse 5 September 2013.

²² “Monitor to investigate NHS contract setting” OnMedica 24 August 2015.

The practice of outsourcing in health has been around for some time and does not necessarily lead to financialisation. However recent reforms have substantially increased the scope for private sector involvement. The commissioners of health services are now required to engage with competition law and to observe the EU Procurement Directive. Given the potential threat of a legal challenge, CCGs are expected to play safe and put contracts out to tender. In addition, a wealth of support is emerging from financial and legal advisers for whom the introduction of anti-competitive legislation into health services is a potential business opportunity. For example, law firm, Hempsons, have produced a guide titled “Cooperation and Competition: A Step Guide for Foundation Trusts and NHS Trusts” which provides advice to protect against legal challenges. They make the point that “Essentially Trusts need to protect themselves against any suggestion that they acting anti-competitively and consider that competition-based complaints are unlikely to come from patients but from other NHS service providers who feel aggrieved or disadvantaged”. Thus, medical practice and clinical processes are increasingly framed in a context of competition law.

4.3 Private income for NHS providers

Most hospital trusts earn some non-NHS income. This can be from various sources such as car parking, education, rental of space as well as the provision of services to private patients. The NHS is a significant provider of private healthcare. In 2012/13 the revenue generated by NHS UK from the provision of privately funded healthcare came to about £500m contributing about 8% of total private healthcare industry revenue. About 96% of this is in England and the majority of this (53%) is in London. There are different policies in the other countries of the UK, in Wales for example there are very few private patient units (PPUs) (CMA 2014, p. 2-7).

This in itself does not necessarily constitute financialisation. The edges between public and private activity in the NHS have long been blurred, for example with NHS doctors also

treating private patients within NHS facilities. However, it is expected that the amount of private income generated will increase substantially in the near future. Under the 2012 HSCA, the cap on the proportion of income that NHS hospitals could earn from private patients was increased from 2% to 49%. Although this only came into effect in 2013, there are reports of large increases in private patient income (ppi) in some hospitals (Table 2) and it is reported that the leading PPUs are “gearing up for growth” (CMA 2014, p. 2-8).

There are two ways in which this is expected to increase the scope for financialisation. First, state hospitals are likely to increase their financially oriented activities. Already, public hospitals are marketing to private patients. For example, Moorfields Eye Hospital NHS Foundation Trust has three commercial divisions - Moorfields Pharmaceuticals, Moorfields Private and Moorfields Eye Hospital Dubai, looking to attract revenue from overseas patients. The Royal Marsden NHS Foundation Trust has a number of non-NHS income streams including research and development in the form of clinical trials and private patient care (Foundation Trust Network 2014, p.4).

Table 2: Income from private patients in selected NHS trusts (£m)			
	2010/11	2013/14	% change
University College Hospital Trust	7.3	10.3	41.1
Royal Brompton Hospital Trust	24.3	33.6	38.3
Moorfields Eye Hospital	16.1	21.3	32.2
Papworth Hospital Trust	4.9	6.4	30.6
Royal Surrey County Hospital Trust	3.6	4.6	27.7
Chelsea and Westminster Hospital Trust	10.7	13.0	21.4

Source: The Guardian, 19 August 2014²³

²³ “Income from private patients soars at NHS hospital trusts” The Guardian 19 August 2014.

Second, private companies, some owned by private equity funds, are making inroads into NHS structures by partnering with FT hospitals. In a report by the Competition and Markets Authority, private health company Spire indicated that the removal of the private patient cap under the HSCA had led a significant number of NHS trusts to explore opportunities to generate additional private revenues including through PPUs. The company expected the trend of NHS facilities seeking to expand their private patient facilities to continue and “there would be significant opportunities for private operators to partner with NHS trusts to operate PPUs in the future” (CMA 2014, p.11-64). Some partnerships have been recently announced. For example, in July 2015 it was announced that US investor, HCA International, was the final bidder left for a contract to build and run a new private patient unit (PPU) for the Royal National Orthopaedic Hospital NHS Trust, the largest orthopaedic hospital in the UK. Spire Healthcare was awarded the contract to manage and operate the existing RNOH PPU in 2012.²⁴ HCA has also partnered with the local NHS Trust in Manchester to construct the PPU known as the Christie Clinic. For the hospital, the deal was expected to treble its private income (rising from £10m to £30m) within a decade.²⁵ In 2011 HCA was named as the preferred bidder for Guys & St Thomas’ to fit out and run a PPU at the Trust’s proposed new cancer treatment centre. The contract is for a 25-year lease. According to press coverage, this is one of several cases where hospitals were entering into agreements in anticipation of the raising of the financing threshold in the 2012 HSCA.²⁶

In Sussex, a new contractual framework has been established between Sussex Partnership NHS Foundation Trust and private equity-owned company, Care UK, to establish a joint company to buy, build and manage mental healthcare hospitals. Called the Recovery and Rehabilitation partnership, the company is building a residential home for patients with mental health issues in Horsham, West Sussex, and has bought a 32-bed mental health hospital in Gosport, Hampshire, opened in 2012. Any profits made by the

²⁴ “Exclusive: HCA is final bidder standing to run new RNOH PPU” HealthInvestor 20 July 2015

²⁵ “NHS trusts bid to attract more private patients” The Guardian 1 August 2010

²⁶ “HCA the preferred bidder for Guy’s & St Thomas’ PPU” HealthInvestor 29 February 2012

50/50 joint venture– mostly earned from fees for NHS patients – will either be split equally or invested back into the company.²⁷

There has, then, been a marked increase in joint undertakings with NHS and private investors. The removal of the PPU cap has been presented as a way of bringing additional revenue to the NHS at a time when funding is desperately needed. For the Foundation Trust Network (FTN), treating private patients brings in funds to subsidise their NHS work:

The importance of non-NHS income streams also need to be considered alongside the immense financial pressures facing foundation trusts and trusts – the provider sector is already in net deficit and a quarter of NHS trusts and a third of acute trusts were in deficit at the end of the financial year. With NHS income squeezed and, at times erratic, given changing tariffs, efficiency requirements and non recurrent funding, the availability of non-NHS income can provide a stable and continuous income stream (Foundation Trust Network 2014, p.4).

Similarly, it was reported on the Manchester partnership with HCA, that initially staff expressed doubts about the scheme until they realised half the income went back into the NHS. Instead of detracting from the NHS, this deal is seen as beneficial. According to a spokesperson from Christie Hospital: “I am only half joking when I say we are the new Robin Hoods, taking from the rich to pay for the poor”.²⁸

For investors, partnering with an NHS trust is an attractive investment opportunity, as capital outlay and risk exposure are lower than those associated with establishing a private hospital from scratch. Typically, there are considerable entry barriers to setting up a private hospital. However, partnering the NHS in a PPU is seen as a “low-risk means of market entry for private hospital operators” (CMA 2014, p. 11-58). Furthermore, long-established, prestigious NHS hospitals offer an attractive “brand” for marketing to private patients. Part of the attraction of being treated as a private patient in an NHS hospital is that there is the full range of NHS general and specialist medical services on site 24 hours

²⁷ “Care UK in joint deal with NHS” Financial Times 10 March 2013

²⁸ “NHS trusts bid to attract more private patients” The Guardian 1 August 2010

a day. Thus, publicly funded healthcare provides a safety net that is attractive to private patients.

Supporters claim that income from private patients subsidises the NHS. However, there is little evidence of this in practice, and subsidies could flow from the NHS to private investors when the wider systemic aspects of provision are taken into account (for example through the use of NHS-trained staff, NHS emergency back up and use of NHS treatment facilities). More research is needed to understand the way that these partnerships between NHS and private investors operate in practice. In particular, analysis of the contractual terms and financial flows could shed light on the extent to which public funds are interlinked with those of private equity and how this is expected to evolve as the projects develop.

4.4 Private Finance Initiative

The private finance initiative (PFI) is the way in which the global trend of Public Private Partnerships (PPPs) has been adopted in the UK. Since 1992 most new capital investment in the NHS has been undertaken through PFI schemes where the private sector finances the design, build and operation of hospitals and these are then leased back to the NHS Trust over a period of decades. By 2012 the Department of Health had more PFI schemes in place than any other government department – 118 in all with a capital value of £11.6bn (NEF 2014). Most PFI investments have been highly geared with 90% funding from debt (Vecchi Hellowell and Gatti 2014). This is the way in which financialisation is most directly established in the provision of health in England.

PFI financing arrangements were politically attractive because they allowed for the construction of infrastructure without appearing to use government funding. Their use was advanced considerably by the Labour Government from 1997 to 2010.²⁹ For NHS providers, there was little alternative source of funds. Financing infrastructure in this way

²⁹ "Gordon Brown's poisoned PFI legacy" The Telegraph 24 January 2011

has, however, been extremely costly, creating extensive liabilities for NHS trusts and has been likened to making purchases with a credit card, in the sense that present consumption is financed by lengthy expensive repayment schedules. For a detailed critique of PPPs and infrastructure finance see Bayliss and van Waeyenberge (2015).

While the financing costs of PFI contracts are a small part of NHS spending (less than one percent overall) they have increased rapidly since 2009 and are a large financing cost for some NHS and Foundation Trusts (Nuffield Trust 2013). PFI payments are contributing to financial deficits not just because of the capital commitments but the inflexibility of the contracts (NAO 2014). The NHS was targeted to make efficiency savings of £20 billion by 2014-15, while at the same time repayments for NHS PFI were expected to reach £4.18 billion. In evidence to the British Parliamentary Review, the British Medical Association indicated that fixed PFI payments would mean that efficiency savings would be more difficult to achieve and health care cuts would be needed in order to meet PFI repayments (House of Commons 2011, paragraph 55).

There are number of trusts that have been struggling with PFI payments. In 2012 the South London Healthcare NHS Trust was dissolved in part due to financial problems relating to two big PFI projects dating back to 1996 (Hellowell 2015). Peterborough and Stamford NHS Foundation Trust has been crippled by PFI debts, paying around £42m a year to service PFI debts, the highest in the country and over 20% of its budget.³⁰ The anticipated cost of the project comes to around £2bn over the 33-year life of the scheme, nearly seven times the £289m original capital value of the new hospital. Millions of pounds have been spent on management consultancy fees in the past five years as the Trust attempted to come up with a financially sustainable solution.³¹ A report on the impact of PFI contracts on NHS services in London found that the PFI schemes in the capital cost £2.7bn to build but will require payments totalling £20.2bn from the fifteen NHS trusts

³⁰ "Peterborough Hospital the NHS and Britain's privatization racket" Open Democracy 19 September 2013 <https://www.opendemocracy.net/ournhs/caroline-molloy/peterborough-hospital-nhs-and-britains-privatisation-racket> accessed 20 August 2015

³¹<http://www.ft.com/cms/s/0/616727e8-be38-11e3-961f-00144feabdc0.html#axzz3FSVyuxW0>

involved in the contracts. Two trusts are spending more than 10% of their income on PFIs (NHS Support Federation 2015). The high costs have prompted the London 2016 mayoral candidate to propose to buy out the PFI debts of London hospitals.³²

Ownership stakes in PFI contracts are traded. Private contractors set up PFI contracts and then on-sell the contracts for a profit. Even where the NHS trusts have had to receive bailout funds to meet PFI payments, PFI shares are traded (or “flipped”) at a profit. The South London Healthcare NHS Trust which was put into administration in 2012 had four sales of equity in its PFI contract (Whitfield 2012, p.43). When the Trust was dissolved, the Department of Health paid for the outstanding costs on the PFI buildings.³³ In 2012 it was reported that PPP equity had been sold in nine other NHS trusts that were reported to be in financial difficulties (Whitfield 2012).

In October 2014, one NHS Trust became the first to buy out its PFI contract. The Hexham General Hospital was opened in 2003. It was built for a cost of £51m but, under the terms of the PFI contract which included maintenance for 32 years, the cost would have risen to £249.1m by the time the debt expired in 2033. Northumbria Healthcare Foundation Trust borrowed £114m from the local council to pay off the PFI contractors for the Hexham hospital and this will save the Trust £3.5m a year over the next 19 years. Several NHS trusts are in financial difficulties in part because of PFI payments. However, it is unclear the extent to which the Hexham cancellation can be replicated elsewhere. This was only possible because of the willingness and ability of the local county council to raise the finance. In addition, some PFI contracts contain large liabilities for interest rate swaps that may raise insurmountable challenges in raising funds to buy them out. Furthermore, the Northumbria PFI contract contained a clause that allowed an early exit which most others do not.³⁴

³² “Mayoral candidate Sadiq Khan proposed buying up London hospital’ PFI debt” The Guardian 20 August 2015.

³³ “South London Healthcare NHS Trust to be dissolved by October 2013” Department of Health Press Release 31 January 2013

³⁴ “NHS trust becomes first to buy out its PFI contract” Financial Times 1 October 2014.

The government is planning to continue to use private financiers for infrastructure with the adoption of PF2 although the aim is to rely less on commercial banks and attract more funds from alternative financial institutions such as pension funds and insurance companies. There is no indication that further privately financed infrastructure will offer any better outcomes for health services and many of the underlying issues with private financing of infrastructure will remain (Bayliss and Van Waeyenberge 2015). The experience of PFI in the provision of health demonstrates that politically expedient measures to increase private investment in a cash-strapped health sector can lead to extensive and problematic long-term liabilities. Furthermore, the financial sector comes out of the PFI model relatively unscathed with contractual payments continuing to be met while hospitals are forced to cut back on employment and other costs, demonstrating its political and economic power compared with other agents in the sector, notably, labour.

5 The investors

So far the extent of entry of private capital into the provision of health has been limited (Table 1) although this is expected to increase rapidly under the 2012 HSCA. As mentioned above, the areas of the healthcare system where private sector involvement was most extensive before the HSCA were in mental and community health services. Experiences in these sectors provide insights into financialisation practices by health companies. In social care, private equity investors have made substantial inroads in the provision of care homes. Here, financialisation had disastrous results in one case. The Southern Cross Healthcare Group was bought by private equity firm, Blackstone, in 2004, which then implemented a “sale-and-leaseback” operation. Under this, the care home properties were sold to a separate company, NHP, which was also owned by Blackstone. These were leased back by Southern Cross which was the operating company, all under the ownership of Blackstone. Blackstone then sold NHP for £1.1bn to a fund backed by the Qatar Investment Authority. At this point the 2008 financial crisis led to falling occupancy rates and a freeze in council payments. Southern Cross could no longer afford the lease

payments to NHP. In addition, the CQC reported poor care standards.³⁵ Southern Cross closed in October 2011. In an enquiry, the company's financial structure was linked to poor care and ultimately the deaths of five residents: "The end result of what happened with Southern Cross Healthcare was that its financial strategy and inadequate focus on care by its responsible managers put vulnerable people at risk".³⁶

Similar sale-and-leaseback operations have been adopted by other healthcare providers. Care UK, described by Corporate Watch as the largest private provider of NHS services, was taken over by the private equity group, Bridgepoint Europe, in 2010. Other investments owned by Bridgepoint include Zizzi Italian restaurants, Fat Face, Leeds Airport and Pret a Manger.³⁷ Bridgepoint operate similarly to Blackstone. When they bought Care UK they immediately created another company, Silver Sea Holdings, to build and own care homes which Care UK will rent from them. The sale and leaseback model was also adopted by Spire Healthcare, the second largest private hospital operator in England. Spire was formed from the sale of BUPA Hospitals to the private equity company, Cinven, in 2007. The company was then listed on the LSE and Cinven had a 38% stake.³⁸ In 2013, Standard Chartered closed a five year £400m senior loan to finance the sale and leaseback of a portfolio of 12 Spire Healthcare hospitals in a £750m transaction. The hospitals were sold to Employees Provident Fund, a Malaysian pension fund that also owns Battersea Power Station. Standard Chartered provided a five-year loan for this. Part of the reason for their comfort with the credit risk is that Spire Healthcare is operating "in a virtually recession-proof industry driven by the country's ageing demographics and the enduring squeeze on NHS resources causing demand to rise year on year".³⁹

Other private equity investors are present in mental health service provision in England. The Priory is one of the largest private providers of NHS mental health services, with 85%

³⁵ "Southern Cross's incurably flawed business model let down the vulnerable" The Observer, 16 July 2011.

³⁶ "Financial strategy of Southern Cross homes blamed for old people's deaths" The Guardian 9 June 2014.

³⁷ <http://www.bridgepoint.eu/en/investment-portfolio/?&page=9>

³⁸ "Market Report: Shares sell off by private equity group Cinven sickens Spire Healthcare" thisismoney.co.uk 15 April 2015

³⁹ "Standard Chartered finances Spire sale-and-leaseback with £400m loan" CoStar Finance 18 January 2013

of the company's revenue funded by the NHS and public sector organisations. In January 2011, The Priory was bought by US private equity group, Advent International, from Royal Bank of Scotland for £900m with around £600m of the purchase financed through debt⁴⁰ with a £600m high-yield bond.⁴¹ The Advent International investment portfolio is extensive and diverse including supermarkets in Poland and hospitals in India. In the UK, investments include insurance and credit card services as well as DFS, described as "the UK's leading sofa retailer".⁴²

Other private equity owned companies receiving NHS funding include Partnerships in Care (PiC), founded in 1977 with annual revenues of more than £170m, mainly from the NHS for specialist hospitals dealing with mental health issues, learning disabilities and substance abuse. PiC was sold by Cinven to Acadia Healthcare Co Inc in the USA for about £394m in June 2014.⁴³ As a result of the deal, Acadia's shares rose as much as 15% on the Nasdaq when the takeover was announced. Acadia which is based in Franklin Tennessee said the deal would add 17-20 cents per share to its earnings in 2014 and 40-46% per share in 2015.⁴⁴

Private finance is also involved in NHS staffing. In 2014, TowerBrook Capital Partners LP "a leading international investment management firm" took over Independent Clinical Services (ICS) from the private equity fund manager, Blackstone. ICS (which trades as Thornbury Nursing Services⁴⁵) is a healthcare employment agency providing staff for NHS trusts, CCGs, local authorities and prisons as well as the private sector. The acquisition was expected to be profitable as it was made "at a time of strong market dynamics for healthcare staffing services in the UK driven by the need to improve efficiency of service

⁴⁰ "Priory hospital owners, Advent International, looking to 'consolidate'" The Guardian 1 November 2011.

⁴¹ <http://www.ft.com/cms/s/0/53f0b960-22d9-11e0-ad0b-00144feab49a.html#axzz3EmxPWhK3>

⁴² <http://www.adventinternational.com/investments/>

⁴³ "Acadia Healthcare to buy UK's Partnerships in Care for \$660m" Reuters, 3 June 2014.

⁴⁴ "Acadia Healthcare to buy UK's Partnerships in Care for \$660m" Reuters, 3 June 2014.

⁴⁵ <http://www.thornbury-nursing.com>

and the continuing emphasis on enhancing quality of patient care at ward level and throughout the NHS".⁴⁶

Other companies involved in health provision tend to be health companies from overseas where private provision is more entrenched. For example the Hospital Corporation of America (HCA) is gaining ground in the sector, particularly through partnerships for PPUs with NHS hospitals through its subsidiary HCA NHS Ventures. HCA is the largest for-profit hospital chain in the USA, bought in a leveraged buyout by three private equity firms in 2006 and then launched on the stock exchange in an IPO in 2011 which generated around \$1bn for the owners.⁴⁷

Meanwhile, Ramsay Healthcare, which earns a large proportion of its revenue from NHS elective surgery admissions, is listed on the Australian stock exchange. In addition, with the expansion of contracts under HSCA, there are more opportunities for large UK companies to diversify into health, such as Virgin Care which bought Assura Medical with a £4m loan in 2010. In 2013 Virgin Care took over the provision of Child and Adolescent Mental Health in Devon in a £130m contract beating competition from two rival bidders.⁴⁸ In April 2016, Wiltshire child health services were transferred from the NHS to Virgin Care under a five-year, £64m contract.⁴⁹

As more private companies are entering the sector, the provision of health is being transformed from a local community service to a segment of global investment portfolios of international private finance. This is likely to have implications for organised labour with employees transferring from the NHS to the contractor (although more research is needed to understand the details of this dynamic). Company share prices are affected by government decisions on the health budget. In addition, companies can be expected to

⁴⁶ "TowerBrook Capital Partners LP agrees to acquire Independent Clinical Services" TowerBrook Press Release 9 June 2014.

⁴⁷ <http://www.bloomberg.com/news/2011-03-04/hca-returning-three-times-cost-shows-timing-the-market-trumps-overhauls.html>

⁴⁸ <http://www.theguardian.com/society/2012/jul/12/virgin-care-children-nhs-devon>

⁴⁹ "Wiltshire child health services transferred from NHS to Virgin Care" The National Health Executive 11 November 2015

engage in financial practices to maximise shareholder returns. For example, in common with water companies, investors in health services have organised their corporate structures to ensure that tax liabilities are minimised. Typically this involves large loans from group companies that create high, tax deductible interest payments so that taxable profit is eroded. Health companies operating this way are reported to include Partners in Care, Independent Clinical Services, Priory Group, Acorn Care, Tunstall, Lifeways, Healthcare at Home, Spire Healthcare and Care UK.⁵⁰

6 Health and water

Financial structures, processes, motives and investors are becoming increasingly entrenched in the provision of health in England. Even within state agencies, transactions are mediated through finance and clinical commissioners are now required to observe international procurement rules. The 2012 sector reforms pave the way for a substantial increase in private sector involvement in the provision of healthcare. Based on the experiences with the provision of water, with the entry of private enterprises, the sector will continue to evolve. The financialisation that has occurred in water in England and Wales was unimaginable at the time of privatisation in 1989. The first owners were large numbers of individual shareholders and then initial de-listing led to water utilities being taken over by infrastructure companies. It was only in the mid-2000s that more predatory financial practices began to be applied with the increase in gearing levels supported by Whole Business Securitisation.

For the health sector, privatisation is taking place in an arena where financialisation is well-established in this country, and private equity firms are already operating on the periphery of health provision. With financial owners in place, the use of financial activities to maximise shareholder distributions takes priority over health outcomes. Rising property values are also exploited as a source of revenue accumulation as shown in the

⁵⁰ "Tax Special Investigation: Firms running NHS care services avoiding millions in tax" The Independent 21 October 2013

sale and lease-back activities of care home providers. This financialisation process means that health services are interpreted in terms of their potential for financial gain in a more creative way than was the case twenty years ago. Attention is paid to revenue streams and asset values as well as the potential for securitisation to enhance shareholder distributions. This is in contrast to the 1980s where privatisation was seen as a way to improve productive efficiency by bringing in private owners.

In many ways, the SoP for health in England is developing along similar lines to the privatisation of water in the 1990s and 2000s. There is a strong emphasis on bringing in competition where possible. The regulator sets prices and mediates between buyers and sellers and intervenes on a selective basis. The state sets the parameters around which investors can organise their operations to maximise their returns. In both sectors, financial investors have established corporate structures to minimise tax liabilities. Private companies in health and water services have close links with the state. In the health sector, there are reports that the private companies involved in the provision of services for the NHS have owners that are connected to the Conservative Party. Donors and lobbyists are reported to have secured lucrative contracts (NEF 2014).

Another striking parallel in both sectors is that England is an outlier in the UK. For water, Wales has been included in the privatisation model but, even within this, Welsh Water is owned by a not-for-profit provider. Water in Scotland and Northern Ireland has never been privatised. In health, Wales and Scotland have not retained the purchase-provider split. They have not put services out to tender with private companies, and the provisions of the HSCA relate only to England.

For investors, the provision of health services offers similar advantages to water investments, with health services set to continue to be funded and so creating secure returns. However, for investors, health is a more risky investment with two key risks being that the government may not pay for services and that the costs may rise according to the underlying health conditions of the patients. Part of the problems faced by the Southern

Cross nursing home model stemmed from government spending cuts after 2008 which led to a reduction in local authority funding for care home admissions.⁵¹

Processes of neoliberalism have shaped both sectors, and narratives have been important in this respect. In health, the framing of the financial position of hospital trusts in terms of deficits, crisis, inefficiency and unaffordability – even though spending levels and performance are consistent with OECD norms – paves the way for greater private sector involvement. In water, the narrative is of a great increase in investment which is held back by the non-payment of water bills by some consumers – even though those that do not pay their bills are known to be the most socially deprived. Meanwhile, the large amounts paid to directors, shareholders and financiers continue, unchallenged. In both water and health, policy discourse underpins a greater emphasis on financialised outcomes.

7 Lessons for foresight

The SoP approach in this case demonstrates that financialisation is a sector-wide phenomenon and analysis needs to look at the structures beyond the proximate parameters set by legislation. The way in which the private sector is involved, and the types of companies operating, varies across different parts of the health service. Investment in hospital PFI contracts has provided relatively low risk long-term revenue streams which have been securitised. Investments that involve property ownership have allowed sale and lease back operations which have increased the scope for financial profits. Corporate structures have been established where high interest payments on inter-group loans lead to lower tax liabilities. These interventions, often by financial companies, bring the state-funded health system into closer contact with systems of financial extraction. Such operations create financialised relations which are not necessarily present in, for example, concession contracts for the private provision of health services or where NHS hospitals treat private patients. However, with greater

⁵¹ "Care home operator warns on profits" The Guardian 9 August 2010.

private sector involvement in the provision of health, there is more scope for financialisation in the future. The tightening of state funding for health has pushed hospital trusts into deficit. Even long-standing trusts that have had no financial problems are now unable to stay within their budgets. Within this context, hospitals are now allowed to earn more private patient income. Into this arena comes the requirement to put services out to tender. This combination of factors looks set to form a springboard for rapid and extensive private sector involvement in the sector. This process has been set in motion and the effects can be expected to continue in the medium term, even in the event of a change in policy.

Some preliminary conclusions can be drawn if the sector continues on its current trajectory. First, the sector is currently on something of a knife-edge. Without more funding, industry observers expect health outcomes to start to suffer. The current government, committed to austerity policies is unlikely to reverse the sector's fortunes. However, the political fallout of a collapse in the NHS is potentially severe. Therefore we can anticipate intermittent "bailout" financing as has been the case in 2014/15. The result is that funding is not part of an overall strategy and the sentiment of inefficiency and unaffordability of the NHS is perpetuated, while there is political mileage from presenting health financing in terms of a "bailout".

Second, the combination of tight budgets and the lifting of the cap on private patient income is expected to lead to a substantial increase in the proportion of hospital revenue generated from privately financed patients. This creates a transformation in social relations and ultimately can be expected to create a two-tier health system, based on ability to pay. While private and NHS patients may be treated separately, they are likely to share access to more expensive treatment facilities. If privately-funded patients are prioritised, conditions for NHS patients will deteriorate. One of the main barometers of the health service is waiting times for appointments for both primary and secondary care.

Where these increase they present a greater burden on home care, the brunt of which is primarily borne by female household members.

Third, more contracts issued by CCGs will be awarded to private sector providers. CCGs are advised to use the tendering process to avoid litigation from private health companies. What this means for NHS providers is unclear. For supporters of reform, this is expected to drive efficiency. However, evidence from the USA indicates that it is more profitable for firms to boost profits by exploiting loopholes or lobbying politicians than improving efficiency or quality (Woolhandler and Himmelstein 2007). Costs paid to financial and legal advisers are expected to increase.

Fourth, although PFI contracts have been shown to present a major financial strain on the health sector, their use is expected to continue under a revised programme known as PF2. This is a modified version of PFI where the aim is to allocate greater risk to the private sector by limiting debt financing of infrastructure projects to 80% of project finance, thereby requiring a greater proportion of equity finance. This, however, is expected to increase financing costs which will be passed through in the contract price and without other sources of finance, "there remains a high risk that more unaffordable projects will be entered into by NHS Trusts, further impacting on scarce NHS resources" (Hellowell 2014, p.5). Finally, labour rights are expected to be weakened with increasing private provision, as employment structures become fragmented across different health providers.

Private health providers tend to benefit from difficulties in the NHS. Rising NHS waiting lists are good for private business, either with the NHS being forced to contract private firms to lower waiting times or with patients seeking privately funded healthcare services. Austerity is likely to present business opportunities for private healthcare providers. For example, Spire Healthcare anticipates an increase in demand for their private health services in light of the financial constraints emerging in the NHS: "The ability of the State to fund increases in NHS provision will remain constrained. The demand gap will grow" and, "The market will continue to grow, driven by economic and demographic growth, by

the widening gap between healthcare demand and the country's ability to pay for the NHS to satisfy that demand."⁵² In terms of foresight, private health providers clearly expect demand for their services to increase. In many ways the UK health system seems to be heading towards the commercialized approach to health management followed in the USA with health commodified like other industries.⁵³

The political climate seems unlikely to change for the duration of the current parliament which will run until 2020. However, there may be greater resistance to financial reforms as the pressures on the NHS start to have greater effect and the strain on households and NHS staff increases. There are now numerous campaign groups centring on the damaging effects of NHS reforms. Opposition ministers have voiced a desire to set up a fund to bail out NHS trusts from PFI schemes.⁵⁴ While this may go some way to mediating the impacts of neoliberalisation of health provision, a far more radical approach is needed to begin to reverse the policy process. And reversal is more difficult as the financial sector becomes more entrenched in provision. As seen above, just one PFI contract has been bought out at considerable cost, although this will generate long-term savings for the local NHS Trust. In water the lack of protest at privatisation is striking in England. While campaign groups call for renationalisation of rail and energy, little mention is made of water. This may be in part because the complexities of ownership are too challenging and costly to unravel. For example, in March 2014 the total debts of the Kemble Water Finance Group, which owns Thames Water, came to over £10.5bn (next to an operating income for Thames Water of just £23.6m in 2014) and incorporates numerous bond issues made by different group companies, some located in the Cayman Islands and some with a maturity date as far off as 2062.⁵⁵ In the current economic climate there is unlikely to be any political appetite for

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<http://www.cinven.co.uk/mediacentre/portfolionews.aspx?mediaid=616><http://www.spirehealthcare.com/Documents/Corporate%20docs/Spire%202013%20Annual%20Report%20final.pdf>

⁵³ For example, management consultants, McKinsey, compare the provision of health care to a car rental company (Carrus et al 2015)

⁵⁴ "Labour must clean up the mess it made with PFI and save the health service" The Guardian comment – Jeremy Corbyn, 26 August 2015

⁵⁵ Kemble Water Finance Limited Investors Report for year ended 31 March 2014.

devoting public funds to water re-nationalisation. As finance becomes more embedded in the health sector, the risk also arises that policies will be difficult to reverse.

8 Conclusion

Applying the SoP approach to the financialisation of healthcare in England shows that the system that is in place today is the result of historically-evolved and context-specific pressures and practices. The financial crisis has been the catalyst for fiscal restraint in health spending. This has been supplemented with legislation to extend the reach of the private sector not just with contracts for services but also with more private patient income allowed in NHS hospitals. Health provision is becoming immersed in financial practices with CCGs wary of inadvertently falling foul of competition legislation. Restructuring has in some areas created lucrative revenue streams for private companies, often backed by private equity investors. The extent of private sector involvement is expected to increase rapidly. Healthcare services are being transformed as funding constraints create a discourse of unaffordability and inefficiency, providing a convenient backdrop to the structural reforms. The result is expected to be a considerable deepening in the cultures of individualisation and commodification associated with financialisation.

Contrary to media discourse, however, the healthcare system in England is no more expensive than most other developed countries and considerably cheaper than the American system. Even within the UK, the measures adopted in England take privatisation much further than in Wales, Scotland and Northern Ireland. There has been some resistance to the policies adopted with some political movements and campaign groups organising with a view to reversing the HSCA legislation. In the May 2015 election, the opposition party campaigned on a pledge to repeal the Act and on 1st July 2015, the NHS Reinstatement Bill was presented to the House of Commons by Caroline Lucas of the Green Party supported by a cross party group of MPs.⁵⁶

⁵⁶ <http://www.nhsbill2015.org/>

However, the current government shows little sign of modifying the Act and even if changes were introduced, this would be too late to stop the momentum of the privatisation already taking place. Once service provision has been transferred to the private sector, policy changes become more complex and more challenging.

Some sectors have seen more vocal campaigns to overturn privatisation and to some degree, by association, financialisation. For example, there is a campaign to renationalise the railways in the UK. In water, there has been little protest and financialisation is difficult to reverse. The impact and reach of financialisation, then, depends to some degree on the way in which the financial sector is engaged in the sector. The divestiture of the water sector and transfer of ownership to private investors is a more profound transition than a fixed-term concession contract. However, with health sector contracts increasingly put out to tender, this may lead to the effective dismantling of the NHS with the state's role reduced to one of commissioning private providers. As such, the ability of the public sector to pose an effective alternative to private and financialised provision of health will be considerably weakened.

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The research programme will integrate diverse levels, methods and disciplinary traditions with the aim of developing a comprehensive policy agenda for changing the role of the financial system to help achieve a future which is sustainable in environmental, social and economic terms. The programme involves an integrated and balanced consortium involving partners from 14 countries that has unsurpassed experience of deploying diverse perspectives both within economics and across disciplines inclusive of economics. The programme is distinctively pluralistic, and aims to forge alliances across the social sciences, so as to understand how finance can better serve economic, social and environmental needs. The central issues addressed are the ways in which the growth and performance of economies in the last 30 years have been dependent on the characteristics of the processes of financialisation; how has financialisation impacted on the achievement of specific economic, social, and environmental objectives?; the nature of the relationship between financialisation and the sustainability of the financial system, economic development and the environment?; the lessons to be drawn from the crisis about the nature and impacts of financialisation? ; what are the requisites of a financial system able to support a process of sustainable development, broadly conceived?

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10	University of Pannonia, Veszprem	Hungary
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