

# Does the United Kingdom's Local Improvement Finance Trust (LIFT) Scheme for Primary Health Care Enhance Partnership Working?

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## Abstract

This article draws on a qualitative case study comparing two U.K. primary health care schemes which were entered into as part of the Local Improvement Finance Trust (LIFT) policy. LIFT takes the form of a social infrastructure Public Private Partnership (PPP) where public procurers and private suppliers work together in active long-term partnering agreements to deliver local primary health care facilities. The organizational structure is that of a joint venture company which is jointly owned by public and private partners, with the expectation that by having both the public and private sector represented on the company board partnership working between the two sectors is enhanced. The two schemes studied delivered contrasting results. One scheme showed how the private sector dominated the board, making partnership working difficult to achieve in the context of directors following their fiduciary role to maximize profits for shareholders. However, the findings from the second scheme showed that partnership working and LIFT success may be dependent on trust, general business ethos, and key personalities working together. Policy makers should therefore pay attention to not only the organizational structures, but also how the private sector controls and governance are exercised to benefit all stakeholders.

## Keywords

public works public private partnerships, roles, social infrastructure, health care, partnership working, governance

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## **Introduction**

Globally, a number of different types of Public Private Partnership (PPP) arrangements have been used to provide social infrastructure, that is, schools, hospitals, social housing, and prisons (Grimsey & Lewis, 2004). Increasingly, especially in Europe, when financial restraints are high, the mixed company format jointly owned by public and private partners has been adopted (Bel & Fageda, 2010). This study focuses on the example of the United Kingdom's Local Improvement Finance Trust (LIFT) scheme in health care, which was announced in 2000 specifically to enable private sector investment in small-scale primary health care projects via a type of PPP, described by policy makers as strategic Joint Venture Partnerships. It was anticipated that 500 projects would require an investment of up to £1 billion (NHS Plan, 2000); however, in total, about 338 LIFT projects having a capital value of some £2.5 billion were developed over the life of the policy (Community Health Partnerships [CHP], 2015).

High performance is seen as critical to the success of PPPs (Hodge & Greve, 2017; Little, 2011) and our objective is to understand how to achieve best practice in the context of strategic joint venture partnerships. We use a cross-case analysis of two LIFT schemes, examining one partnership between public entities and a regionally based private company, contrasting it with a partnership in which the private partner is a company whose ultimate shareholders are multinational organizations. Research on these Joint Ventures has been relatively limited but has raised a number of complex governance-related issues (Agyenim-Boateng et al., 2017; Aldred, 2006, 2008; Beck et al., 2010; Shaoul et al., 2012; Stafford & Stapleton, 2017), suggesting the need to deploy more sociotechnical, multidisciplinary, and processual approaches (Broadbent, 2012; Hodge & Greve, 2018; Humphrey & Miller, 2012), to enhance our understanding of partnership working in hybrid forms of PPP.

The rhetoric surrounding this policy program is about joint ventures and partnerships, which gives the appearance of coherence with the underpinning context of the U.K. National Health Service (NHS), which is that health care is free-at-the-point-of-delivery. However, as in practice, the LIFT schemes are delivered through limited liability companies where the ownership is controlled by the private sector partner; profit is a significant motivator for the way the LIFT scheme is run (Agyenim-Boateng et al., 2017). While the ownership structure creates tensions with the rhetoric of partnership, the main focus of our study is to explore whether it is still possible to create good partnership relationships within this for-profit context.

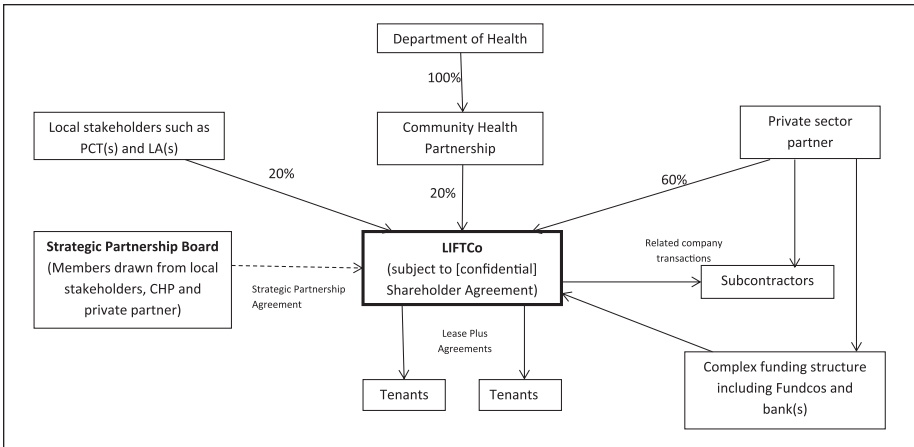
While the knowledge embodied in cultures can serve as a resource for building and facilitating inter-organizational collaboration, culture can also create barriers to effective partnership working (e.g., Beck et al., 2010), and conflict and mistrust may result (English & Baxter, 2010). Thus, we seek to identify those factors that may undermine or facilitate partnership working in LIFT and to understand how differences in ethos and their implications for partnership working can be managed within each LIFT scheme. We therefore aim to address the research question: How do trust and culture undermine or facilitate partnership working processes in practice?

## Background to the LIFT Program

The NHS, which is largely funded from general taxation, provides the majority of health care in England and consequently accounts for the majority of the Department of Health's budget. Primary care—the first contact for a patient with the health care system—accounts for 90% of all patient contact with the NHS, and when the LIFT scheme was introduced was provided by primary care trusts (PCTs). PCTs were public bodies that offered readily accessible basic health care services in multidisciplinary health centers based in English communities. They cover a local geographical area which is similar but not necessarily identical to the relevant local government area (Agyenim-Boateng et al., 2017). Until they were abolished in March 2013,<sup>1</sup> PCTs held about 85% of the total NHS budget and were responsible for planning, securing, funding, and coordinating all NHS services in a defined geographic area. The PCTs' budget was formula-based and dependent upon the size of the local population and some specific local needs. Their role was to commission health care on behalf of the local population from hospitals and general practitioners and to disburse funds to these service providers according to departmental guidelines on an agreed tariff or contract basis (The NHS Confederation, 2011). PCTs were expected to make decisions about how NHS resources should be invested in the context of national policies, regional strategies, and other local PCTs' activities. Whereas a contractual form of PPP had been used extensively to fund hospital development, the mixed company (Marques & Berg, 2011) format of LIFT aimed to attract investment from the private sector to develop primary and social care services and facilities, many of which had become dilapidated due to inadequate and piecemeal investment (National Audit Office [NAO], 2005).

At local level, a LIFT scheme was implemented when a PCT initiated a competitive tender process between private sector bidders. The successful bidder then set up a local joint venture company co-owned by public and private partners. The theoretical rationale behind such mixed companies is to structure an equilibrium between cost-efficiency and social concerns (Da Cruz & Marques, 2012). The local joint venture is a Special Purpose Vehicle but is always described in the LIFT program as the LIFT Company (LIFTCo). In practical terms, the LIFTCo designed, financed, built, and operated PCT buildings under a contract that could last up to between 25 and 30 years (NAO, 2005; Public Accounts Committee [PAC], 2006). Thus, the LIFT companies provide buildings and facilities management services but not medical services. These long-term contracts tie in the PCTs but guarantee the private sector's cash flow (Agyenim-Boateng et al., 2017; Aldred, 2006). Buildings are leased to tenants under agreements, known as Lease Plus Agreements (LPAs) which regulate the occupation of the LIFT facilities and establish the rights and responsibilities under the lease.

The partnership working arrangements, as set out by the Department of Health, include having a LIFTCo, a Strategic Partnering Agreement (SPA), and a Strategic Partnering Board (SPB). The SPA sets out the commitments and duties of the public sector and the LIFTCo signatories. The SPB is described as running the local LIFT scheme (Department of Health, n.d.) and is the guardian vehicle of the SPA



**Figure 1.** Shareholder and partnership working relationships in LIFT.

Source: Adapted from NAO (2005).

Note. LIFT = Local Improvement Finance Trust; PCT = primary care trusts; CHP = Community Health Partnerships; LA = local authority.

————> Contractual relationships, percentages indicate ownership of LIFTCo.

- - - - -> Governance relationship.

commitments. The SPB comprises members drawn from the private and public sector partners and is intended to be accountable to each of these participants' organizations. Its functions include undertaking strategic planning for the estates required to support primary health care provision, holding LIFTCo to account for its performance in delivering services, and resolving disputes between the parties (CHP, 2014a). While the SPB could be seen as a key component of the framework to propose new projects and monitor existing ones, like other joint venture projects (Shaoul et al., 2013), its main role became the development of new projects rather than the monitoring of existing ones. In practice, the LIFTCo becomes a shell company, with virtually no assets and liabilities, apart from some very small equity capital and a board of directors. Figure 1 shows the shareholder and governance arrangements in LIFT, as designed by the Department of Health. In each scheme, the private sector partner is expected to own 60% of the equity capital in the LIFTCo with the remainder held by the public sector, initially<sup>2</sup> divided equally between the local stakeholders and a national public sector body, CHP. The LIFTCo delivers the outputs of the contract by subcontracting with companies that are related parties to the private sector shareholders of the LIFTCo. Again, as is often the case with PPP, finance raised by the private sector is normally debt capital, with over 90% of capital structure being debt (Beck et al., 2010).

A fundamental rationale for the LIFT program was that through the joint venture partnership arrangement public and private partner organizations would collaborate to generate mutual benefits (Russell, 2008). Good partnering would be assisted by a

**Table 1.** List of Interviewees.

Case	Interviewees	Organization	Position
JV1	D1a	PCT1	Former CEO, Chair of Board
JV1	D1b	PCT1	Finance Director, PCT
JV1	D1c	PCT1	Director of Corporate and Public Affairs, PCT
JV1	D1d	JV1 Ltd	CEO
JV1	A1	Accounting firm	Advisor to LIFT scheme
JV2	D2a	LA	Former chairperson of the SPB for JV2
JV2	Q2a	PCT	Finance Director, PCT
JV2	Q2b	PCT	Deputy Finance Director of PCT

Note. PCT = primary care trusts; LIFT = Local Improvement Finance Trust; LA = local authority; SPB = Strategic Partnering Board.

shared vision of “the end game” and a similar ethos between all parties engaged (Russell, 2008, p. 4). But in practice LIFT schemes have been criticized for working in a top-to-bottom mode, because plans are set through high-level structures which are usually closed to the public and patients. Such structures put an extra barrier between managers and service users (Aldred, 2006). Furthermore, this program gives the private sector companies a strategic partnering role with the PCTs and thereby expands their involvement beyond building and maintenance so that they become part of the PCTs’ long-term plan (Beck et al., 2010). That is, they become part of the strategic planning and commissioning of health care services representing the majority of the health budget. It is in this context that we examine the ways in which the partnership arrangements operate in practice.

### The Research Approach and Case Study Information

We use a qualitative cross-case analysis (Miles et al., 2014) approach, focusing on two purposively chosen cases anonymized as JV1, whose private partner is a regionally based company, and JV2, whose private partner is a large multinational corporation. Data gathering involved analysis of financial reports relating to both schemes, together with additional public domain information. This data was complemented by in-depth, semi-structured “elite” interviews with senior managers. Five interviewees were connected to JV1, one of whom was from the private sector and the rest from the public sector. Although we approached other managers from the public and private sector side of JV2, only one senior public servant, who was once a chair of the SPB of JV2, agreed to be interviewed. However, two senior finance managers, from the public sector, with knowledge about the implementation and management of the JV2 scheme did agree to answer a semi-structured written set of questions. In addition, a private sector advisor with a range of functional responsibilities for implementing the two schemes was also interviewed. Details are shown in Table 1.

To increase data reliability, we used multiple sources of data to seek confirmation and clarity (Miles et al., 2014). Data gathering and analysis was organized around key issues in partnership working and related governance activities. Interviewees were selected because they held appropriate and senior roles in relation to the LIFT project and were particularly individuals with knowledge of governance, partnership working, and financial reporting at a senior level in the NHS, in NHS-related companies or in the relevant LIFT companies.

## The Case Studies

Consistent with the plan that launched the LIFT scheme, in both our cases, the LIFTCo is owned by the selected private partners, PP1 and PP2 Ltd, CHP, and the local shareholders in the ratio of 60%, 20%, and 20%.

JV1 was set up in 2003 in a relatively rural community in England by two PCTs. The private partner PP1 Ltd is a regional construction and facilities management company, which has a number of subsidiaries and investment interests in various companies that also provide construction and facilities management services. PP1 Ltd's parent organization is PoPP1 Ltd which is owned 51% by an individual, who founded the company and gave the remaining 49% of the shares to a charitable organization. The founder's shares will pass, under the terms of his will, to the charity after his death. Consequently, the LIFTCo shareholder PP1 Ltd. is described by interviewees as having an ethos that is similar to the public sector, because although the business is run as a for-profit company, a good proportion of profits is subsequently given to the charitable trust.

The JV2 scheme is located in a relatively urban community and has been in existence since early 2003. It offers a number of contrasts to the JV1 scheme. JV2 was initiated by six PCTs, which later merged into three, and three separate local government partners, so that the local 20% shareholding is more widely dispersed than in JV1. The private sector partner PP2 Ltd's parent is owned by PP2 holdings Ltd, which is in turn owned equally by a multinational infrastructure organization (InfraCo Ltd) and an international bank (BanCo Ltd).

## Analysis and Discussion of Empirical Findings

While the rhetoric underpinning a joint venture partnership suggests that public and private sector entities would create a partnership that would share beliefs, values, and attitudes and norms of behavior, in practice the pre-determined control over the LIFTCo board creates expectations that the public sector partnering organizations will share in the profit-making motive to avoid conflict and facilitate partnership working. But from the perspective of some public sector participants, the dominant control following on from the ownership percentages raises questions about how these partnerships are governed, and how oversight operates and for whose benefit. We now present and analyze how this underlying context played out in practice in our two companies in rather different ways that are associated with the informal structures and relationships within the participating companies.

The empirics suggest three inter-related issues of informal workings, namely, the culture or ethos of the private sector partner; the quality of leadership, especially in the public sector partners; and perceptions about openness or a lack of transparency.

### *Corporate Culture*

Effectiveness in mixed companies is not easy to define but may involve stable and cooperative working of a relational nature that enables the partnership to cope with unforeseen circumstances (Da Cruz & Marques, 2012) and may involve long-term social exchange and mutual trust (Reeves, 2008). NAO (2009) identifies four key factors that create an effective partnership, two of which—aligned interests and a spirit of cooperation<sup>3</sup>—are specifically referred to in LIFTCo SPAs. For JV1, the ethos of the private sector partner (PP1) appeared to be critical to the good working relationships that were reported. PP1 was described as being both more in line with a public sector ethos and loyal to a specific local geographic area. As the Chief Executive Officer of JV1 Ltd observes,

Yes, definitely more in line with public sector ethos . . . they run their business at a profit, but a good proportion of that profit goes straight into a charitable trust with which they do work across (the regional area where the JV1 scheme is located). (D1d)

This was supported by another public sector director who adds,

They've also got quite a strong community ethos in terms of putting back into the area, . . . which I think we value because it says something about their philosophy. (D1c)

The community-focused character of this particular company and its directors was also acknowledged by a private sector advisor (A1) to the JV1 scheme:

In terms of bidding for schemes, they've not gone for schemes all over the country. They've been very much focused in the geographical area.

This closer alignment of ethos and loyalty to the local community was perceived to result in closer more responsive working relationships, which in turn may have enhanced the perception of shared ethos. One interviewee commented about the private partner,

. . . they do have dedicated individuals based in the JV1 area, . . . So there's a local team in all the buildings who we are familiar with and work with. (D1b)

One respondent, who has had experience of less good working relationships with private sector directors elsewhere<sup>4</sup> speaks of how in this organization JV1 private sector directors take pride in the mutual benefits of partnership:

I genuinely think the difference is philosophy. They take a very long-term view of the partnership. They want the partnership to work. They wish to retain a good reputation.

And also all the partners have the same philosophy. I think we're actually quite proud of our LIFT buildings and we want LIFT to work and we want it to do well. And in this area I think it has done exceptionally well. (D1d)

This represents an example of how the theoretical benefits of the mixed ownership form may be translated into practice (Da Cruz & Marques, 2012). Whereas by way of contrast, for JV2, PP2 Ltd's dominant voting power controlled the LIFTCo board working practice:

The power dynamic from the Board really comes from the private partners . . . I do not consider this as an equal relationship. (D2a)

The use of its domination was attributed to the corporate culture of the JV2 private partner, which belongs to a multinational organization. The partnership was characterized as being full of mistrust and the term "anti-partnership" was used by a public sector director to describe his frustrations with the relationships:

It was quite a frustrating experience, I think, and I know that not all LIFT partnerships work in the same way. But ours very often didn't feel like a genuine partnership arrangement . . . it was very commercially focused.

### *Quality of Leadership*

Distinctions existed between the cases in terms of the quality and effectiveness of the public sector leadership. A small number of partners and consistency of leadership over time are generally recognized as influential factors in providing good leadership. JV1 had just two local public sector partners with co-terminus geographic boundaries, and it was reported that this worked well: "you haven't got a cast of thousands that changes at every meeting" (D2a). In contrast, not only did the JV2 scheme commence with nine partners, but also there was a merger partway through the scheme when the leadership changed:

So I think that the lack of stability actually affected the ability to work properly. (D2a)

Unlike other forms of PPP, LIFT involves the planning and delivering of a series of discrete projects over time, creating opportunities for partners to build up experience and trust in partnership working. At JV1 planning, the discrete projects established interactions between the partners that led to strong perceptions of joint working and good outcomes.

I think the difference compared to, say, PFI,<sup>5</sup> you know PFI is a one-off, kind of build it, it will never do that again, from the Trust side. Because you've got a number of schemes coming along here after a period of time, there's further discussion and learning each time from the lessons. And they've been actually on the Board as well, it's more partnership working. It's not the opposite sides of the table, contractual line in the sand, it's different to that. (D1c)

In this case, the joint ownership format worked to reduce the distance between partners evident in more contractually based PPPs (Da Cruz & Marques, 2012); however, there was no evidence of this incentive at JV2.

Interviewees saw weak local public sector leadership as a concern, because it undermined partnership working but also made it impossible for directors to strike a balance between priorities, as in the LIFT structure the public partners are both shareholders and tenants of the scheme, which creates conflicts of interest. As shareholders the public partners, like their private partners, require directors to generate strong cash flows and financial returns as is consistent with the shareholder agreement. However, as tenants the public partners wish to buy services and tenancy as cheaply as possible. One interviewee noted that the willingness of key public sector leaders to stand up to the private sector directors on the board is hugely important if priorities are to be balanced.

Nevertheless, public sector leadership was not uniformly weak, at least in as much as strong leadership is defined as a human agent's ability to capture benefits. As D2a observes in relation to JV2:

In who got the most out of the actual LIFT program out of those three [public] partners, I'd say Local Authority<sup>6</sup> 1 by a long way. And I think what made the difference for Local Authority 1 was very strong, very good leadership at the top of their PCT. I think their PCT was way more pragmatic than the one in (another authority) was and actually thought. Well, if this is the only show in town, we're going to get everything out of it we possibly can and really went for it. And they've got some fantastic buildings in Local Authority 1, you know, really beautiful buildings that function amazingly well. And to me that was how they did it . . . —because the local leadership was very strong.

Expertise was identified as a significant factor affecting participants' ability to exercise leadership within the board room context. With JV2, the relevant local government partner lacked experience in capital project delivery and its interests were not a dominant force in the board room. Consequently, LIFT was described as a missed opportunity:

And I think part of that was the inability of our local PCT to really understand any kind of capital strategy, you know, any kind of property strategy at all really because it's quite a new thing for them and I don't think they had the expertise to be able to do it. (D2a).

So quality leadership requires some reasonable amount of expertise. That is, to accrue some good benefits for the public sector from partnership working it is important to have a team of experienced leadership from the public sector side of the partnership.

### *Lack of Transparency*

Despite finding that mixed form PPPs are sound in principle, Marques and Berg (2011) argue that there are more serious problems with design and implementation than are

widely recognized. Their recommendations for improvement strongly advocate greater transparency at all stages of the project, including design implementation and performance reporting. Our respondents from the public sector blamed the profit-making motivation, especially in the JV2 case, for the lack of openness they perceived during implementation surrounding information about project costs. Speaking of the JV2 case, one director argued that, in contrast to better experiences on other projects, this partnership

felt quite confrontational a lot of the time, and it was very difficult in terms of the finances to get the private half of the public/private partnership to be transparent. So very often when we were questioning costs, it was very, very difficult to get to an explanation of why their costs were high if we felt the costs were high. It was quite difficult to get them to be completely open with us

However, understanding partnership relationships is not straightforward. One interviewee raised questions about why these negative perceptions had taken hold. Whereas in the JV2 case, this interviewee reported that the private partner InfraCo was perceived to be unresponsive, such perceptions did not match the interviewee's own experiences with the same company on another project.

## **Conclusion and Policy Implications**

Our empirical findings contrast two cases. The JV1 interviewees recognized a reasonably close alignment between the private partner corporate culture, due to strong charity connections, and the public service ethos of the public sector partners. In JV2, the private company is a multinational organization with a culture closely focused on profits, and therefore less well aligned to that of the public partners.

While the U.K. government had expected partners to aspire for "synergy" in intersectorial relations, in practice, existing relationships exhibited some tensions. While JV1 exhibited close partnership working, with partners reporting a good alignment of interests, in JV2, different assumed motives had created a degree of suspicion and lack of trust between partners, with public organizations sometimes uncomfortable when faced with the underlying profit motive of their private sector partners. Nevertheless, it is important to recognize that the JV2 partnership had not suffered a breakdown in relations and in common with many other LIFT schemes is perceived to have delivered good-quality buildings (CHP, 2014b).

Although like all studies our findings should be tempered with a degree of caution, we can identify some ways in which partnership working and governance practices might be improved for social infrastructure projects.

First, the empirical evidence shows how in the PPP environment a regional company with charitable associations is perceived to be performing well. Yet, in many PPP arrangements, small companies have struggled to win contracts in an environment that is increasingly globalized and may even struggle to make bids in complex contractual arrangements (Aldred, 2006). But more closely aligned community-based interests

appear to have reduced the tensions inherent in this joint venture structure so that working cultures are more easily aligned. This lends support to the view that aligned organization cultures matter for the formation and maintenance of LIFT partnerships (Beck et al., 2010). Governments could commit to design policy programs that enable small local businesses and charitable organizations to partner the public sector in similar joint ventures.

Second, greater information sharing among public and private sector directors should be encouraged, in the spirit of cooperation and trust suggested by the NAO (2009) to enhance partnership working. Public sector directors need more transparency about intercompany pricing and contract changes. Moreover, more sharing between public sector directors across schemes would enhance the experience and skills they bring to the governance of projects.

Third, the lack of strong commissioning and strategic planning skills among public sector managers remains a constraint on the ability of the public sector to capture contractual benefits whether under LIFT or in other ways. Without these the intended synergistic development of the LIFT (Beck et al., 2010) and other similar schemes will accrue to the private sector, not the taxpayer or citizen. In this respect, the lack of continuity of public sector oversight and monitoring of projects after the construction phase, despite the large sums of money involved in the operating phase, is a concern for taxpayers and citizens as the health sector increasingly moves in the direction of commissioning from the private sector. Stronger use should be made of the SPB to continue its scrutiny role throughout the operational stage of projects.

This study shows the importance of context and illustrates the complexities of the social world. Our findings show that where public and private sector interests were more closely aligned, both health care and profit agendas could be pursued. The study shows that government and practitioners need to consider contextual differences in various PPP environments and to make appropriate reconfigurations to deliver social infrastructure that meets the needs of all stakeholders.

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### **Notes**

1. Primary care trusts' (PCTs) responsibilities were taken over by newly formed Clinical Commissioning groups.

2. After the PCTs were abolished their shares were transferred to Community Health Partnerships (CHP).
3. The others are clear understanding of roles and responsibilities under a contract and satisfaction with remuneration.
4. The Chief Executive Officer had this experience when he was working in the public sector.
5. PFI is another form of PPP arrangement used in the United Kingdom where it attracted huge investments to the big U.K. hospitals.
6. Local government entities are often referred to as Local Authorities in the United Kingdom.

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