



**MEMORANDUM TO:** Standing Committee on Social Policy

**FROM:** Bob Gardner  
Director  
Public Policy

**DATE:** January 31, 2006

**SUBJECT:** **Research on British-type Purchaser-Provider Funding Model**

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Some stakeholders have expressed concern that the government will move towards the type of split purchaser-provider model used in the UK, in which the government purchases services from a wide range of providers through competitive bidding and in which there is extensive for-profit provision. In our appearance before the Committee on January 30, we were asked to provide references to British research on the impact of this model.

### **British Experience**

This memo highlights a few examples of recent research and analysis; more detailed research can be undertaken if needed:

- The Institute for Public Policy Research is one of the leading British policy think tanks, well connected to the current government. It undertook a Commission on Public Private Partnerships, with business, government, academic and union representation, from 1999 to 2001 to “try and forge a consensus on the role of the private sector in delivering public services.” Further information is available at <http://www.ippr.org.uk/ipprcommissions/?id=87&tid=87> Its 2001 report was wide ranging:
  - on health care, the value-for-money evidence does not indicate significant gains for Private Finance Initiatives in health;

- they generally supported a role for private funding and service provision, but argued that far clearer objectives, criteria and performance monitoring was needed;
- they emphasized that the “government must play a pivotal role in promoting good employment across the public service sector: public money should not support poor employers.”
- they also argued that “the assumption should be that public purchasers will involve citizens and service users in the process of selecting providers.”
- A more recent comprehensive survey of available research and analysis is Allyson Pollock, *NHS plc: The Privatization of Our Health Care*, London: Verso, 2004. It provides data on significant problems with the UK model in terms of higher overall administrative costs, quality of care and working conditions.
- The Kings Fund, an independent British health research and policy foundation, has developed bibliographies and other information resources on partnerships and integration  
[http://www.kingsfund.org.uk/resources/information\\_and\\_library\\_service/index.html](http://www.kingsfund.org.uk/resources/information_and_library_service/index.html)
- There has been a great deal of media and public discussion with current problems with privately financed hospitals.
  - The government is currently “halfway through the biggest hospital building programme in the history of the NHS. Yet even before yesterday’s proposed shift 5% shift of resources from hospitals to the community, some 60 hospitals were running serious deficits. The £9B still due to be spent on 40 new major private finance initiative hospitals needs to be seriously reviewed and cut back. Most of these involve 30-year payback contracts and the hospital scene is changing much too fast for such lengthy deals.”<sup>1</sup>
  - Ms Hewitt had earlier called for a review of a major hospital rebuilding project in east London. There appear to be growing concerns about the abilities of hospital trusts to bear the costs of servicing long-term PFI arrangements, especially in the context of revenue uncertainty resulting from proposed payment by results funding. A leading British academic was quoted as saying: “This is an early signal of all that is going to happen to big PFI schemes in due course. The bigger they are, the bigger the financial hole that has to be filled. The more ambitious ones will be scaled back.”<sup>2</sup>
- A unanimous House of Commons Select Committee on Health report <http://www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/646/646.pdf> was critical of recent policy regarding consolidating primary care trusts, which are responsible for 80% of the NHS budget and commission services from public and private providers. It felt evidence was far from clear that costs savings or improved commissioning would result:

<sup>1</sup> “Hewitt’s primary prescription” Leader, *Guardian* January 31, 2006. Patricia Hewitt is Health Secretary (Minister in our terms, Leader is an editorial and the reference is to changes announced in a just released White Paper).

<sup>2</sup> *Guardian*, December 28, 2005.

- it saw little evidence for consolidating trusts into larger trusts and argued this would be offset by loss of local focus;
- it doubted that anticipated savings would materialize. Because the trusts are such a large part of the overall health budget and played such a crucial role in commissioning direct service provision: “it is probably a false economy to deplete the NHS’s managerial resources in an attempt to save only a fraction of that total amount.”
- it worried that the main rationale for consolidating trusts – to strengthen their commissioning function – would be ineffective unless closely connected to improved incentives for the provider sector;
- most fundamentally, it was concerned about the destabilizing effects of continual reform on front-line provision: “... just as the benefits of PCTs (established in 2002) are about to be realized, the Government has decided to restructure them. The cycle of perpetual change is ill-judged and not conducive to the successful provision and improvement of health services.”

## Home Care in Ontario

There has also been some academic research indicating potentially problematic effects of competitive bidding and for-profit contracting in home care. Specialist provider agencies will be able to provide the Committee with much more detail, but recent examples are:

- Julia Abeleson et al, “Managing under managed community care: the experiences of clients, providers and managers in Ontario’s competitive home care sector,” *Health Policy* 68, 2004: 359-372. They found problem areas to be increased transaction costs, quality of care and continuity concerns raised by both providers and consumers, and provider morale.
- Several studies have found that the shift to competitive bidding led to intensification of work, increased casualization of work, lower pay and benefits and increased job insecurity. For example, a cross country survey found that wages of home care workers were lower in non-unionized for-profit agencies: Human Resources Development Canada, *Canadian Home Care Human Resources Study*, 2003.
- A more specific study by Margaret Denton et al, *The Impact of Implementing Managed Competition on Home Care Workers’ Turnover Decisions* (presented to the Institute for Research on Public Policy conference on Health Services Restructuring, November 18, 2005 ) found that turnover among nurses and personal care workers rose and was directly related to these factors.
- The extensive review of the competitive bidding process used by CCACs, chaired by former Minister of Health Elinor Caplan, heard that certain features of non-profit agencies – such as providing extra (meaning non-mandated) services to meet specific needs and their connections to local communities -- were much valued by clients. However, it did not analyze in detail continuity of care, satisfaction, working conditions or other variables by type of provider. *Realizing the Potential of Home Care* Ministry of Health and Long-term Care, 2005: Ch 8

## **Our Conclusion**

The LHINs will not actually be funding services for several years so there is plenty of time to fully consider the best funding options and service mix. More importantly, there is time to conduct this analysis and debate in a public and transparent fashion, in keeping with the government's emphasis on community engagement.

We argued that the most effective funding model and whether for-profit provision should be part of the mix that can be considered in the various planning conferences, forums and consultations we recommended in our full policy paper. [http://www.wellesleycentral.com/ip\\_lhins.csp](http://www.wellesleycentral.com/ip_lhins.csp) The Ministry should not allow or endorse for-profit provision until and unless its superior programme effectiveness, quality of care, innovativeness, working conditions and other cost-benefits are demonstrated.