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Contract, social relations and the outsourcing of publicly funded healthcare

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ABSTRACT

A prominent and consistent element of Chris Newdick's work can be understood as a focus on the nature of relations in healthcare and healthcare law. Specifically, he has emphasised and defended the importance of social solidarity and community as core values against the dominant focus on and championing of an individual sense of autonomy in those areas. This article takes up the theme of relations in a different context, exploring the nature of the social relations underpinning the increasing role played by the private sector in delivering publicly funded healthcare. It does so by considering two instances of outsourcing – the private finance initiative and the United Kingdom (UK) Government's awarding of contracts as part of its response to the Covid-19 pandemic. It is argued that those examples disclose relations between the state, citizens, and what the sociologist Wolfgang Streeck calls the *marktvolk* (the people of the market) that cannot be comprehended via the notions of solidarity and community traditionally associated with a publicly funded healthcare system like the UK's National Health Service. Indeed, the social relations involving the *marktvolk* – including, for instance, the importance of one's status and duties of loyalty based on acquaintance – tend to have the effect of, in Newdick's phrase, 'corroding [the traditional form of] social solidarity'. Thus, while important, it is not only the stress on individual autonomy and rights that has this corrosive effect; other forms of social relations – including those involving elites and revolving around capital – have this impact too and demand exploration.

Keywords: contract; social relations; outsourcing; publicly funded healthcare; Covid contracts; private finance initiative.

INTRODUCTION

An enduring feature of Chris Newdick's work has been its focus on the nature of relations in healthcare and healthcare law. Specifically, against the dominant focus on and championing of an individual sense of autonomy in those areas, he has emphasised and defended the importance of social solidarity and community as core values. We see this, for instance, in

his analysis of the *Watts* case,[1] in which he notes a development – namely, individual rights to access healthcare in European Union member states – that may, in Newdick's words, be 'likely to damage the sense of social solidarity essential to any public, social welfare system'.[2] In another article, and in line with Newdick's advocacy of a communitarian approach to healthcare issues, he urges us to think of autonomy in a more relational way than is traditionally the case, stressing the importance of understanding and acknowledging the circumstances and environments within which individuals live. And rather than placing too much emphasis on individual responsibility when it comes to promoting and protecting health, he argues that we need to pay heed to 'the social and commercial determinants of inequality and dependency'.[3] Newdick's suggested way forward is to strive for a 'public health "ethics"' which exemplifies 'non-ideal theory' and manifests itself in a call for 'an acceptable balance of competing outcomes and aspirations [including "between public and private interests"]'. – 'to rebalance the relationship between [what Wolfgang Streeck calls the] *staatsvolk* and *marktvolk*'.[4] That is, between 'the general citizenry' (citizens have a duty of loyalty to the state in return for it protecting them through the existence of social rights) and the 'people of the market' (the state increasingly seeks to sustain this constituency's confidence and the relationship between this group and the state is defined by contractual ties; in other words, unlike citizens, the *marktvolk* do not owe a duty of loyalty to the state, though maintaining their confidence in the ability of states to service the debts they owe the *marktvolk* is crucial). Newdick's suggestion, then, is that there has been a shift away from 'public interests'/solidarity/ the *staatsvolk* in favour of 'private interests'/individual autonomy/the *marktvolk* and that this constitutes an imbalance in need of redress.[5]

This article takes up Newdick's emphasis on the relational dimension of healthcare and healthcare law by considering the phenomenon of the outsourcing of publicly funded healthcare in the United Kingdom (UK).

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1 *R (on the application of Watts) v Bedford Primary Care Trust and Another* [2006] All ER (D) 220 (May)

2 C Newdick, 'Citizenship, free movement and health care: cementing individual rights by corroding social solidarity' (2006) 43 Common Market Law Review 1645–1668, 1645.

3 C Newdick, 'Health equality, social justice and the poverty of autonomy' (2017) 12(4) Health Economics, Policy and Law 411–433, 427.

4 Ibid 427–428. See W Streeck, *Buying Time: The Delayed Crisis of Democratic Capitalism* (Verso 2014).

5 For some suggestions as to how this rebalancing might occur, see C Newdick, 'Global capitalism and the crisis of the public interest – sleepwalking into disaster' in S C Breau and K L H Samuel (eds), *Research Handbook on Disasters and International Law* (Edward Elgar 2016).

It does so by focusing on the mechanism through which outsourcing has occurred – namely contract. In one sense, contract is apposite as a focal point as it enables reflection on the growing role in healthcare of the *marktvolk*. As contract is traditionally understood as being central to the operation of markets, it would seem like an appropriate place to look to try to understand the role the 'people of the market' play in the context of publicly funded healthcare. Simultaneously, it will be argued that contract presents an opportunity to identify and explore the kinds of social relations at play, and at stake, in contemporary publicly funded healthcare as well as their effect on the solidary notion of social relations underpinning an institution such as the UK's National Health Service (NHS). This kind of exploration involves digging down beneath the surface appearance of contract and the particular exchange between the contracting parties to reflect on the character of the relations between, say, the state and the *marktvolk*, and the *staatsvolk* and the *marktvolk*. With the introduction of the private sector and the profit motive into a publicly funded healthcare system, such as the NHS, which was founded on anti-market principles and values, it involves thinking about what types of relations need to be in place for capital to flourish in this sector, as well as the distinctive form of social relations that capital introduces into the system. Using the private finance initiative (PFI) and the Covid-19 pandemic as examples, the article identifies a variety of forms of relations that structure the contracts in those areas. Moreover, it is argued that those relations tend to have the effect of, in Newdick's phrase, 'corroding social solidarity' – that is, the notion of social solidarity traditionally associated with a publicly funded healthcare system such as the NHS. It is suggested that this form of corrosion is not only caused by the contemporary stress on individual autonomy and individual rights, but is also the result of capital and elite relations too. To begin, however, let us first turn to consider the principles underpinning Aneurin Bevan's vision of the NHS at its founding. This will then allow for a consideration of the impact on these of subsequent developments.

BEVAN, THE NHS AND SOLIDARITY

To contextualise the discussion of contract and the *marktvolk* that follows later in the article, reference will be made to the ideas and principles underpinning Aneurin Bevan's vision of and for the NHS, which was established in 1948. The Labour Minister of Health at the time, Bevan viewed the NHS as an institution founded on socialist principles of community, universalism, and need. As he said: '[M]edical treatment and care should be a communal responsibility that … should be made available to rich and poor alike in accordance with medical

need and by no other criteria.'[6] This 'collective principle', as he called it, was designed to create a healthcare service in which universal access to healthcare, hitherto absent from the pre-NHS patchwork system of healthcare, became a reality. Moreover, access to treatment was not to be conditional upon the payment of charges by patients; rather, it would be funded via general taxation, thus reflecting the communal and progressive nature of the institution. Essentially, Bevan's vision for the NHS was one in which the profit motive and commodification were to be banished from the world of medical treatment and care. In terms of social relations, the NHS was not akin to the market exchange traditionally associated with contract, which predominantly characterised the relationship between doctor and patient prior to the founding of this institution – namely, payment in return for a service. Nor, relatedly, was the legitimation underpinning its mode of financing – general taxation – to be understood in a transactional, utilitarian sense (what Leroy describes as 'exchange tax' – I expect to receive the amount of healthcare equivalent to the amount of tax I have paid).[7] Rather, the idea of social relations inherent in Bevan's NHS can be thought to equate to a notion of solidarity synonymous with the principle underpinning the Roman law concept of *obligatio in solidum* – that each member of a group is 'liable for the reversals of fortunes of another'. This idea of all for one and one for all is consistent with a healthcare system driven by the common good in which nobody needing it should be denied access to medical treatment just because they lack the means to pay for it. Moreover, as noted, liability is the binding force of the *obligatio in solidum* rather than, say, blood or love. Thus, citizens are liable to those in need of medical treatment and care, irrespective of the fact they are not blood relatives or friends. Those founding and guiding principles of solidarity and the common good find expression in Leroy's notion of 'contribution tax', the legitimacy of which is synonymous with progressive, redistributive welfare policies that are supported by taxpayers despite no immediate, or indeed any, return in exchange for one's contribution.

Bevan's notion of communal responsibility is synonymous with ideas of social justice and fairness that, it is suggested here, characterise at least part of what Newdick means when, in the context of the *Watts* case for example, he talks of social solidarity. There is a sense that the emphasis on individual rights in that case compromises the carefully constructed solidary elements – waiting lists, for example – of a healthcare system like the NHS. Newdick's take on solidarity, however, is presented in the context of the dangers of a system driven

6 A Bevan, *In Place of Fear* (Heinemann 1952) 75.

7 M Leroy, *Taxation, the State and Society: The Fiscal Sociology of Interventionist Democracy* (Peter Lang 2011).

by individual rights. Thus, allowing the latter to dominate may mean that finite resources are diverted to the 'affluent' or 'articulate' with detrimental consequences for others and the idea of social solidarity underpinning the institution.[8] While important, it is not only in this context that questions arise about solidarity, the promotion of the public interest, and how these are being affected. Other forms of relationship need to be brought into the mix too if we are to think about those issues in the round. Those relationships are not just those of individual to community, but of state to finance, and citizens to both finance and state. Reflecting on these latter forms of relationship is crucial to both developing an understanding of the kinds of social relations at play in the context of contemporary publicly funded healthcare systems and identifying their effects on the notion of solidarity synonymous with Bevan's vision of the NHS. The remainder of this article makes a start in pursuing this form of enquiry. As indicated earlier, it does so by considering the role that contract increasingly plays as an important mechanism through which several features of the NHS and publicly funded healthcare are planned and delivered today. The next section begins this enquiry in the form of a discussion of two examples of contract – PFI contracts and so-called 'Covid contracts'.

TWO CONTRACTS – PFI AND COVID-19

PFI contracts

First, let us turn to what are here called private finance initiative (PFI) contracts. With such contracts, a private finance company – known as a special purpose vehicle (SPV) – is established and it finances, builds and maintains, for example, an NHS hospital for the duration of the contract term (typically in the range of 25–40 years). Clinical commissioning groups (CCGs)[9] lease the hospital and staff, such as cleaners, from the SPV, and during the contract term pay unitary charges, which cover services provided by the SPV, debt repayment, and financing costs (including often very high interest payments on the original loan, usually from a bank to the SPV). Those payments come out of the NHS budget. While the Government announced in 2018 that it would no longer use PFI for future building projects, given the duration of the existing contracts, the high levels of payments will continue for many years to come.[10] In 2022, it was reported that 101

8 Newdick (n 2 above) 1652.

9 As a result of the Health and Care Act 2022, CCGs, which were created by the Health and Social Care Act 2012, have been abolished and replaced with integrated care boards.

10 L Booth, 'Goodbye PFI' (House of Commons Library October 2018).

NHS trusts still owed around £50 billion in future unitary payments.[11] In 2020–2021, of the £2.3 billion the trusts spent on PFI projects, £457 million was used to pay interest charges to private companies, the equivalent of 15,000 newly qualified nurses' salaries. Some trusts spent more than half of their total unitary payments on interest charges.[12] As indicated, this means less money for patient care and staffing, which is compounded by the prospect of NHS trusts having to make future cost savings. The unitary payments, on the other hand, are guaranteed and rise in line with inflation, thereby compromising further the resources available for healthcare. From the perspective of those private sector actors involved in the funding, construction and management of PFI contracts, there are definitely profits to be made. A 2017 report by the Centre for Health and the Public Interest (CHPI) found that the vast majority of PFI healthcare contracts overseen by the Department of Health and Social Care (DHSC) and in existence at the time (107 of 125) had, over the previous six years, produced £831 million in pre-tax profits for the PFI companies involved.[13] This was on top of the profits made by others from those contracts, such as banks and construction companies. In addition, £480 million in dividends was also paid out on those contracts, amounting to almost 5 per cent of all the money the NHS paid under the contracts. Finally, the report notes that, by 2017, only eight companies had equity stakes in 115 (or 92%) of the 125 DHSC PFI contracts. As the report's authors note, this raises doubts over the claimed competitive basis/rationale of the PFI tendering process and questions about the possibility of abuse of market power in the context of existing contracts.[14]

In the context of this article, two questions arise from such data. First, what are its possible implications for the notion of solidarity underpinning the NHS? Secondly, what can PFI contracts reveal about the forms of social relations at play in today's NHS? As those questions are inextricably linked, the analysis that follows will not admit of clear demarcations when responding to each question in turn. An initial response is that the PFI does not have much of an effect on the idea of solidarity underpinning the NHS. For, despite PFI, general taxation still funds this public healthcare system and grounds its operation in accordance with principles such as access to treatment being based on one's need rather than ability to pay. Millions of people continue to receive treatment free at the point of need, including those unable,

11 M Goodier, 'NHS hospital trusts paying hundreds of millions in interest to private firms' *The Guardian* (London 25 October 2022).

12 Ibid

13 Centre for Health and the Public Interest, PFI: Profiting from Infirmaries (August 2017) 4.

14 Ibid 4.

for whatever reason, to pay tax. It therefore retains its communal and progressive character.

As noted above, however, PFI contracts have the effect of diverting some of the NHS budget away from the treatment and care of patients (reducing the money available to recruit more healthcare staff, for instance), thereby, in Newdick's term, corroding the original sense of solidarity discussed above and undermining its foundational principles. But, if this is the effect of PFI contracts, how might we explain the manner in which it occurs? What forms of relations underpin this type of corrosion? The following are two possible, and related, ways of approaching those questions. First, rather than the solidarity amongst citizens envisaged by Bevan, the PFI contract creates another form of social relation – namely that between creditor and debtor; the creditor (putting up the money) being the SPV and the debtor (accepting that money as a loan with interest that must be repaid) being the public body, or more broadly we could say, the state. And if citizens' taxes are the source of the debt repayments to the private sector, citizens might also be characterised here as debtors in a relationship with creditors. If liability for our fellow citizens in need of medical treatment (liability 'for the reversals of fortune of another') is the bonding force at the heart of the NHS as Bevan imagined it, the bonding force in the context of PFI contracts, while still liability, is a communal liability of debtors (the state and its citizens) to creditors (finance capital) – in other words, to a group outside of the solidary group (citizens) at the heart of the original vision of the NHS. Thus, despite the importance to it of citizens and the presence of a form of communal liability, this debtor–creditor relation is not a solidary one. Rather, it is a relation of power, driven by the needs and imperatives of capital and its constituency – the *marktvolk*. In the context of PFI contracts, at least, it is those needs and imperatives, rather than the demands of patients or claims of individual rights to medical treatment or the political objective of patient empowerment via increased choice, which result in the corrosion of Bevan's notion of solidarity. For the diversion of the NHS budget to the *marktvolk* contributes to the provision of fewer services, resulting in longer waiting lists, which, as seems to be occurring presently, lead to increasing numbers of citizens paying privately for treatment.[15] This, in turn, further jeopardises the NHS's solidary basis. Decisions to look for treatment outside of the NHS are predominantly driven by a lack of adequate state funding, a state of affairs to which PFI contracts will continue to contribute for the foreseeable future.

15 P Duncan and D Campbell, 'One in eight UK adults using private medical care due to NHS delays' *The Guardian* (London 15 December 2022).

Another, related, way of comprehending this erosion of solidarity in the context of PFI contracts is by reference to Brett Christophers' analysis in his book *Rentier Capitalism*.[16] Rent, as Christophers defines it, is '*income derived from the ownership, possession or control of scarce assets under conditions of limited or no competition*'.[17] Christophers' argument is that contracts (including PFI contracts) used to outsource the provision of services fit this definition insofar as the contracts themselves are the scarce assets over which certain companies – the rentiers of the outsourcing sector – have monopoly control. As he says:

> These contract assets are scarce in the sense that each is unique, and they are by nature limited in number … [T]hey frequently encompass the delivery of services for a period of years – even, in some cases, decades – and the income they generate thus takes the form of rent: income guaranteed by virtue of possession of an asset that insulates the contractor from all competition for the contract duration.[18]

Christophers' analysis prompts several points that are pertinent to the present discussion. First, beyond the scarce (NHS) resources, identified earlier, that function as the pool of money from which rentiers derive their income, Christophers identifies a further layer of scarcity in the context of what he terms 'contract capitalism' or 'contract rentierism' – namely, the scarcity of the contracts themselves. This scarcity tends towards the existence of monopoly power, with a limited number of companies being awarded contracts for outsourced services, something that would seem to be borne out by the CHPI's findings, cited earlier, showing that, by 2017, only eight companies had equity stakes in 115 of the 125 DHSC PFI contracts. As noted, those findings tend to confound claims about the competitive basis/rationale of the PFI tendering process and thus lend support to Christophers' point about the lack, rather than strong presence, of competition in the context of contract rentierism generally.

Secondly, 'contract capitalism' points to the central role of the *marktvolk* in the private and public sectors today, and, for present purposes, specifically within the sphere of publicly funded healthcare. Of course, as we have already seen by reference to Newdick's work and the discussion above, one way of characterising this is as a relationship between the *staatsvolk* and *marktvolk*, skewed in favour of the latter. But what Christophers' analysis alerts us to is not only the crucial consequences of 'contract rentierism' for the *staatsvolk* but, equally, the importance of understanding the nature of the relationships

16 B Christophers, *Rentier Capitalism: Who Owns the Economy, and Who Pays for It?* (Verso 2020).

17 Ibid xxiv. Emphasis in original.

18 Ibid xxxiv.

between the state and the *marktvolk* that are generative of the very existence of rentierism, of which contract capitalism is one example. The nature of those relationships is apparent in a 1965 essay by E P Thompson, which Christophers cites as evidence of the character of rentierism's revival in the UK during the 1960s and 1970s. Thus, Thompson identified one of the core characteristics of what he called a new 'predatory [rentier] complex' as being 'its interpenetration of private industry and the State (Government contracts, especially for war materials, of an unprecedented size, subsidies, municipal indebtedness to private finance, etc.) ...'.[19] Another was the state's central role in the revival of rentierism, a theme stressed in Christophers' account of the phenomenon. For instance, he argues that the growth of financial rentierism in the UK in recent times has been spearheaded by governments and powerful groups within them 'that have actively privileged the financial sector and financial activities'.[20] This focus on agency is also apparent in relation to the scarcity mentioned above and its production. Christophers cites John Maynard Keynes, who argued that earning interest on loaned funds depended on the existence of a scarcity of loanable capital. This scarcity, however, was not a natural phenomenon, but, Keynes argued, the result of a class project – capital had to be made scarce in order for the lucrative interest rates charged to access it to be possible. This focus on the active role played by the state dovetails with Streeck's notion of the debt state insofar as one of its key roles is to continue to borrow the *marktvolk*'s money and pay interest on it. Moreover, as noted earlier, as an important constituency that contemporary debt states must keep on side, Streeck argues that the state must actively seek to maintain the confidence of the *marktvolk* as well as demonstrating to this group its credibility in the form of being able to service its future debts. This important relationship between the state and the *marktvolk* will be taken up further in this article's final substantive section.

Finally, PFI contracts have a certain temporal dimension; as noted above, they can endure, often for several decades. Consequently, for those companies holding the contracts, they function as a steady stream of income over a period of time extending long into the future. As Christophers says, the contract of 'contract rentierism' should be characterised as an asset as 'it embodies futurity: the contract refers to future rather than historic or immediate ("spot market") exchange, and the value of the asset to its holder is the value of the future net cash flows it will elicit'.[21] PFI contracts are therefore often not ephemeral entities; rather, they bind the state and its citizens in for the long term.

19 Quoted in Christophers (n 16 above) 22.
20 Ibid 54.
21 Ibid 229.

What emerges from the foregoing discussion of PFI contracts is that, if we are to understand Newdick's contention that the idea of solidarity traditionally underpinning the NHS is being corroded, it is necessary to focus on the types of relations that are having this effect. Doing so means looking behind the surface appearance of such things as PFI contracts as mere entities of exchange to explore the nature of the relations between, on the one hand, the *marktvolk* and the state, and on the other, the *marktvolk* and the *staatsvolk*. This enables identification of the kinds of conditions required for the existence and maintenance of such contracts, as well as for the corrosive effects that flow from those conditions. The following section continues this type of analysis by reference to the example of what are here called 'Covid-19 contracts'.

Covid-19 contracts

At the outset, it is important to note the scope of Covid-19 contracts. On the one hand, they cover matters directly related to healthcare, such as contracts for the supply of personal protective equipment (PPE) to the NHS. Covid-19 contracts also include the Government's broader management of the pandemic – for instance, the award of contracts to firms that ran focus groups to assess the best way for Government to communicate important information about the pandemic to the public. For the avoidance of doubt, reference to Covid-19 contracts in this article includes both types of contract.

Several controversies have, and continue to, surround Covid-19 contracts. Two of these will form the focus of attention here. First, there have been much-publicised allegations of cronyism – that is, of those working in government effectively awarding contracts to their acquaintances. The second concerns the amount of PPE items that are unfit for purpose and thus designated as waste. Is there evidence pointing in these directions; if so, what might this tell us about the relations at play in Covid-19 contracts, as well as the possible implications for the notion of solidarity? These are the questions to which the discussion in this section is directed.

Taking allegations of cronyism first, reference to a couple of recent judicial review cases brought by the Good Law Project (GLP) can assist here. The argument advanced is that the cases point to the presence of personal and social relations/connections at different stages of the process leading to the award of contracts. Thus, in one case concerning the award of a contract (to a company called Public First) for the provision to the Government of focus group and communications support services without public notice or competition, the High Court upheld the GLP's ground of challenge that the award gave rise to

apparent bias contrary to principles of public law.[22] As the defendant had not produced objective criteria which they could show had been used to select Public First over other research agencies, the High Court found that it had not been demonstrated that the procurement was fair and impartial and that there was, consequently, 'a real possibility, or a real danger, that the decision-maker was biased'.[23] Although O'Farrell J was at pains to stress that Mr Cummings's (who was, at the time, the Chief Adviser to the Prime Minister) professional and personal connections with Public First did not mean he was unable to make an impartial assessment as to which organisation could deliver the required services, it is difficult to divorce the finding of apparent bias from those connections, which the defendant (the Rt Hon Michael Gove (then Minister for the Cabinet Office and Chancellor of the Duchy of Lancaster)) also had with Public First's owners and directors. Indeed, the GLP's 'apparent bias' ground of challenge was founded on the existence of those personal connections, the nature of which are set out in detail in the High Court's ruling.

Another case concerns the so-called high priority (HPL) or VIP lane, whereby various groups – Members of Parliament (MPs), ministers, and senior officials, including those in the NHS – could email a dedicated email address indicating opportunities from people who had contacted them wanting to supply PPE.[24] One concern with the VIP lane was that it functioned as a mechanism by which officials could recommend the businesses of acquaintances as suppliers of PPE and fast-track their interests in being awarded contracts. The importance played by personal relations, at least insofar as getting onto the HPL was concerned, seems to be borne out by this case, in which the GLP sought judicial review of decisions by the Secretary of State for Health and Social Care to make direct awards of contracts for the supply of PPE and medical devices to three companies. The company director of one of the companies – Pestfix – contacted the Chief Commercial Officer

22 *R (on the application of The Good Law Project) v Minister for the Cabinet Office* [2021] EWHC 1569 (TCC).

23 This ruling was subsequently reversed by the Court of Appeal as it found that there was no requirement on the decision-makers to conduct any procurement process and thus no requirement on them to identify objective criteria that had been applied in selecting one rather than another research agency. Mr Cummings was able to award the contract directly. See *R (on the application of The Good Law Project) v Minister for the Cabinet Office* [2022] EWCA Civ 21. Despite the ruling, the Court of Appeal reiterated the evidence of the personal, social and professional connections between Public First and the decision-makers, especially Mr Cummings. GLP's request for permission to appeal the Court of Appeal's ruling to the Supreme Court was refused in December 2022.

24 *R (on the application of Good Law Project Limited and Everydoctor) v The Secretary of State for Health and Social Care* [2022] EWHC 46 (TCC).

at the DHSC indicating that he was a good friend of his father-in-law's and that they had met at the father-in-law's recent 80th birthday party. In subsequent emails to staff, the nature of the relationship – that the director is an old friend of his father-in-law's – is relayed by the Chief Commercial Officer. As a result of the referral, the company was placed onto the HPL, subsequently being awarded a number of lucrative contracts for the supply of PPE. Another of the companies – Ayanda, which is engaged in private equity, trading, asset management and trade financing – was awarded lucrative PPE contracts worth £252.5 million. Ayanda was allocated to the HPL after an adviser to its board, who formerly was an adviser to the Board of Trade for the Department of International Trade (DIT), contacted the Director of Global Trade and Investment at the DIT suggesting that the PPE deal he was proposing 'really needs Ministerial attention'. The Director of Global Trade and Investment suggested to other officials that it 'should be fast tracked through the system', which it was.

Beyond those legal cases, evidence of the importance of connections and acquaintances to successful referrals to the VIP lane, and to securing subsequent contracts, continues to mount.[25] This obviously raises the issue of potential conflicts of interest, something identified by the Public Accounts Committee (PAC) in the context of the award by the DHSC to Randox Laboratories Ltd of contracts for Covid-19 testing services and goods worth almost £777 million.[26] It found that the DHSC did not demonstrate 'any evidence of taking any care over potential conflicts of interest when it awarded contracts to Randox' despite the then Secretary of State for Health and Social Care – Matt Hancock MP – having received hospitality from Randox in 2019, and Owen Patterson MP, who had contacts with the Secretary of State for Health and Social Care, having been one of Randox's paid consultants. The PAC also expressed concern about the disproportionate (high) value of contracts for testing services having been awarded to testing suppliers on the VIP lane, that had been referred by, *inter alia*, government ministers, MPs and the Prime Minister's office.

As noted above, the second area of controversy concerns the vast amount of PPE which is currently in storage as it cannot be used by frontline staff. The following data from the National Audit Office provides details about this issue.[27] More than 3.6 billion PPE items,

25 See, for example, the following items on the GLP's website: 'LEAKED: The Conservative politicians who referred companies to the PPE "VIP lane"'; 'REVEALED: Greg Hands referred close political contact for £25m VIP contract'.

26 Committee of Public Accounts, G*overnment's Contracts with Randox Laboratories Ltd* (House of Commons 27 July 2022) 28.

27 National Audit Office, *Investigation into the Management of PPE Contracts* (House of Commons 30 March 2022) 1144.

costing £2.9 billion to purchase, are in storage because they cannot currently be used for frontline services, which is 11 per cent of all PPE the Government has received: 1.5 billion of these have expired (passed their sell by date); and 1 billion items of PPE, costing £439 million, are wastage, meaning that it cannot be used for any purpose. From March 2020 to October 2021, the DHSC paid £737 million to store PPE, which included penalty charges of £436 million for having to store it for longer than they envisaged. The DHSC annual accounts for 2021–2022 show that the department was spending an estimated £24 million each month on PPE storage costs.[28] Exemplary of the controversies surrounding PPE, the GLP cites the case of Uniserve, a company assigned to the VIP lane after referral by the Conservative peer, Lord Agnew. The company was awarded PPE contracts worth £300 million and subsequently provided £178 million of PPE which the Government classified as 'do not supply' (to frontline workers). Uniserve was then awarded a contract worth £138 million to store PPE.[29]

What might the two foregoing controversies, and related information, disclose about the relations at play in the context of Covid-19 contracts? Let us return to one element that Streeck stresses in his analysis of the relationship between the state and *staatsvolk* – namely, a duty of loyalty. As we saw earlier, he argues that citizens owe the state a duty of loyalty in return for the protection of social rights afforded to them. Of course, we might think such a duty was present during the pandemic – people generally abided by the regulations set by the state and expressed loyalty to the NHS and its founding principles, including in the form of solidarity with its workers and those citizens requiring access to treatment as a result of having contracted the virus. Thus, some with non-Covid related illnesses may have held off attending hospital to ensure priority was given to those with the virus. And it could be argued that longer waiting lists demonstrated the existence of a more pressing health need and an instance of a communal liability for the reversal of fortunes of others (Covid-19 patients). It is suggested here, however, that the controversies cited above point towards the existence of two other duties of loyalty at play, but this time in the context of the relationship between the state and the *marktvolk* (here, those companies/firms that secured government contracts for the provision of materials and services related to Covid-19). The first resides at the micro level. This takes the form of a duty of loyalty on the part of state officials to market players in the context of specific contracts. This duty of loyalty may arise, for instance, out of friendship

28 Department of Health and Social Care, *Annual Report and Accounts 2021–22* (26 January 2023).

29 See 'REVEALED: PPE storage costs hit £1bn as "VIP" firm Uniserve's profit soars'.

or having been a former colleague, especially where the person could demonstrate links to government in the sense of having contributed to it in some form. Here, then, we might note the importance to the award of Covid-19 contracts of certain sets of social relations or networks, which themselves exhibit a sense of community or even solidarity between state officials and the *marktvolk*. The ties that bind here might not be so much grounded in liability but in something more akin to status and, if not blood or love, then acquaintance. It is who you are, whom you know, whom you have worked with, that seem to matter. The second duty of loyalty lies at the macro level. In July 2020, the British Medical Association (BMA) produced a report indicating the vast scale of the outsourcing of work and tasks by the Government in the course of the pandemic, as well as the use of large sums of public money that sometimes did not produce high-quality products and technology (they give the example of test and trace).[30] The examples cited earlier would seem to confirm both the extent of this outsourcing and its results. It is argued here that what this scale of outsourcing discloses is a state loyalty, in a more general sense, to the market and capital, rather than to provision of services by the public sector.

The two foregoing duties of loyalty differ from Streeck's characterisation as, firstly, they are not manifestations of loyalty owed *to* the state in the context of the relationship between the state and the *staatsvolk*, but rather *by* the state to the *marktvolk*. And, secondly, the return on this form of state loyalty does not necessarily equate to the protection of citizens' or indeed public healthcare workers' health, as confirmed, for instance, by the BMA's findings and the vast amount of wasted PPE. Rather, it enhances the profit margins of the companies/firms to whom the work was outsourced and produces large amounts of debt, the repayment of which will potentially further affect the resources available for, among other public services, the NHS. As noted earlier, diminishing resources affect this institution's solidary basis as the principle of universal access based on need alone is compromised, together with Bevan's notion of communal liability, as those able to afford it feel increasingly compelled to resort to the private sector. That other sense of communal liability that was encountered in the discussion of PFI contracts above – a liability of citizens to the *marktvolk* in the form of repayment of debt – will, however, be reinvigorated.

30 British Medical Association, *The Role of Private Outsourcing in the COVID-19 Response* (July 2020).

CONCLUSION

Chris Newdick's work has contributed significantly to putting the ideas of community and solidarity squarely on the agenda of healthcare lawyers and those researching healthcare more generally. In doing so, he has opened up for discussion and analysis the broader theme of the nature of relations in the context of publicly funded forms of healthcare and the ways in which these may have changed, and be changing, today. Taking the outsourcing of such healthcare as its point of departure, this article has sought to identify and analyse the kinds of relations underpinning and flowing from some of the contracts associated with this phenomenon. Two conclusions emerge.

First, the contracts explored here mark something of a shift in the kinds of social relations underpinning the NHS. While this institution still displays evidence of Bevan's vision of it as a solidary, collective entity founded on the principle of access based on need rather than ability to pay, the PFI contract illustrates the partial erosion of this notion of solidarity and its replacement by a non-solidary communal liability of the *staatsvolk* to the *marktvolk*. Here, it is the debtor–creditor relation and the emerging significance of the *rentier* that is important.

Secondly, and relatedly, the discussion of Covid-19 contracts in this article raises the issue not merely of the corrosion of traditional understandings of solidarity and community underpinning publicly funded healthcare, but of how that may occur precisely via the operation of other forms of solidarities, communities, and/or networks – specifically those fostered in the context of the relationship between the state and the *marktvolk*. As Ralph Miliband wrote of economic elites, they exhibit 'a high degree of cohesion and solidarity, with common interests and common purposes which far transcend their specific differences and disagreements'.[31] Those other forms of solidarity and community, and the nature of the ties and bonds they exhibit, demand further research if we are to grasp the changing state of publicly funded healthcare and the steadily increasing role of capital and the *marktvolk* within it.

31 R Miliband, *The State in Capitalist Society* (Merlin 2009) 35.