

# Reinventing the Commonwealth Development Corporation under Public-Private Partnership

by  
Sir Michael McWilliam, KCMG

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## Reinventing the Commonwealth Development Corporation under Public-Private Partnership: reflections on the privatisation of CDC

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### Preface

By Andrew Hilton, director, CSFI.

A major experiment is currently underway in the development area – but it is one that has attracted very little attention (in the press or elsewhere) so far. That's a pity, because what the UK government is trying to do with the 52-year old Commonwealth Development Corporation merits a lot more serious analysis than it has received to date. Perhaps UK financial journalists are too cynical (or too jaded) to give much attention to the never-ending task of improving the efficacy of Western aid.

In essence, what the Labour government has launched is something that the Conservative administrations of Mrs Thatcher and John Major refused to take on – the privatisation of Britain's premier aid agency. Since – if the Treasury and the Department for International Development succeed - this will be a global first, with huge implications for the rest of the international development establishment (not least the Bretton Woods institutions), it is worth having a look at what is in store. The CSFI did late last year in the form of a round table with Bowen Wells MP, and it was sufficiently impressed to commission (if that is not too peremptory a term) a paper on the subject from Sir Michael McWilliam, who is currently writing a history of the Corporation and who sat on its board for some years.

Why does the CDC experiment matter? And why do we attach such importance to it?

First, CDC may be a small player next to the World Bank group's IFC (with which it is usually, and quite favourably, compared), but it has clout. Its gross investment portfolio is around US\$2.4 billion, invested in over 400 businesses in 55 developing countries. It also manages around US\$230 million of third party funds, and (prior to the Asian crisis, which hit it hard) had been earning around 8% on capital employed. Second, in recent years it has shifted increasingly into equity – although around 60% of its portfolio is still made up of loans. That is a route that it clearly wants to take – indeed, it is one that it has tried hard to promote particularly since the beginning of the 1990s. To the general chagrin of its management and staff, however, it has been thwarted over the years by both a chronic squeeze on the UK's aid budget and by the rather mysterious refusal of the Treasury to countenance any direct approach to the markets as a substitute for public funds.

In 1993, the Conservative government of the day did review the possibility of “liberating” CDC from government shackles – but, ultimately, lost its nerve and did nothing. Ironically, a significant factor in this was the implacable opposition of the Labour party, for whom “privatising aid” was anathema. It was, therefore, a big surprise when the new Labour government announced that its very first privatisation (well, public-private partnership, but it means much the same) would be CDC.

Clearly, the timing for this is better now. In particular, a new chief executive has recently been recruited, with impeccable private sector credentials – Alan Gillespie, latterly a managing director at Goldman Sachs. Nevertheless,

it is still a radical step – though the government seems committed. Indeed, a Bill has already been pushed through Parliament converting CDC from a government agency to a (government-owned) PLC. Moreover, the new company has been given a unique fiscal status, which effectively allows it to avoid capital gains tax. In the first quarter of this year, CDC's balance sheet will be restructured, and, sometime over the next three or four years, the intention is that around 65-70% of CDC's equity will be sold to private investors (with the proceeds going straight into Britain's aid programme). Of course, the government is not pulling out entirely: it insists that it will retain its minority shareholding for the long term, and there is a "Golden Share" that (unusually) carries no expiry date. More significantly, the Articles of Association of the new company bind it to follow the investment policy laid down in a statement agreed with the government. This commits CDC, even in private hands, to invest 70% of its funds in the least-developed countries, and 50% in Africa and South Asia.

Can this possibly work? This remains the most crucial question – one for which, as yet, there is no answer. To attract private investors, CDC will have to demonstrate that it can earn consistent total returns (dividends, interest, realisations etc.) well in excess of 20%. Given the 70/50 split (and the almost visceral fear that many private investors have about Africa), CDC will probably have to show returns closer to 30% — a far cry from the 7-8% it was earning before the Asian crisis.

The new tax status will help – but no one thinks it will close the gap. Rooting out waste, fraud, etc may also boost returns a little, but CDC is already pretty lean. So how will the gap be closed? Given Mr Gillespie's background, we can expect a lot more creativity when it comes to structuring deals – but that prospect carries with it a lot more risk. So does an almost exclusively equity orientation in an institution whose culture has been predominantly that of a lender. As some more cynical politicians have already suggested, this could also mean that CDC will have to look for the loopholes in its mandate – which might mean cherry-picking whenever it can in the poorest countries. It might also mean closing some offices, cutting back on non-remunerative technical assistance etc. None of this is very attractive, and it is obviously important to minimise any damage to the overall aid effort.

In this area, DfID (which will control the government's stake in CDC) seems willing to take up some of the slack. The government may also be prepared to restructure some of the UK's broader aid programme around CDC investments, so as to enhance their return. As Sir Michael points out, there is also always the possibility (given that we have some time before privatisation is actually imminent) to tweak CDC's mandate a little. Perhaps, for instance, a more market-friendly approach would be to abandon the formal 70/50 investment allocation requirement and create instead a "development regulator", who would review CDC's progress periodically in terms of the development targets set by the government. The City is already comfortable with regulators in other fields (telecoms, utilities etc); it would not stretch the imagination too far to conceive of a similarly-constituted development regulator (?OFDEV).

Even so, bringing CDC into the private sector with such a tight development mandate is not going to be easy, and success is far from guaranteed.

But what if it works? What if the new CDC model does demonstrate that, with creativity and government support, the private sector can make an acceptable return out of equity investments in the very poorest countries? What future then for IFC? Indeed, for the World Bank itself? Notwithstanding Sir Michael's very genuine enthusiasm, we at the CSFI remain a bit sceptical that Labour can pull this astonishing trick off. But the memory that everyone who was at our round-table took away was that of the conventional development establishment on the defensive – while CDC appeared as the harbinger of a new development dawn. If Labour's public-private partnership works, the Washington consensus is in for a nasty shock.

## Introduction

**A radical  
step...**

After half a century in which, as a public corporation, the Commonwealth Development Corporation (CDC) became a distinctive element of Britain's overseas development strategy, Tony Blair has reversed the accepted wisdom (reaffirmed as recently as 1993), and has announced that the Corporation is to be moved into the private sector. Legislation was passed by Parliament last year, which has resulted in CDC becoming a government-owned public limited company at the beginning of 2000. That said, the government has also insisted that CDC will remain in public ownership until conditions are right for disposal, and that it intends to retain a minority stake for the long term as a demonstration of public-private partnership. In addition, the CDC Act entrenches a development mandate for the new company. But privatisation is now a very real and imminent prospect.

**...but a  
difficult one**

This paper examines the reasons for the government's policy switch over privatisation, and some of the implications – both for the UK and more widely (since what is happening to CDC could easily be seen as a model for other development agencies).

The proximate cause for the change in CDC's status was that the Corporation had been progressively cut off from new funding through the UK aid budget, and had been simultaneously prevented from raising external loans from the market. This was the outcome of departmental policies which ministers from both major parties had endorsed. Yet this outcome was not inevitable; the new direction that CDC is taking is not the only one that could have been envisaged – nor, necessarily, is it the best.

Those who are responsible for CDC's future are well aware of the problems associated with privatisation – both real and perceived.

As a result, the new CDC Act entrenches a development mandate through new Articles of Association, which will ensure that the bulk of the Corporation's investments continue to be made in poorer countries, especially in Africa and South Asia. As is widely accepted, this mandate will be hard to square with the need to make CDC attractive to private investors. This paper argues that an alternative (and perhaps less destabilising) approach would have been to establish a Development Regulator, which would have been more market-friendly. This could still be one way of enabling the government to do without the permanent minority shareholding that it currently envisages, without abandoning CDC's development focus.

Until now, CDC has never had to meet financial performance targets that would be acceptable to private investors. Now, it is being told that it must change the habits of a lifetime. True, the government has acknowledged that there will be a transition period for CDC to reorganise its investment portfolio and to establish investor credibility. But this is no mean task. Moreover, any attempt to force the pace will result in a widening discount to book value for CDC's shares — and in reduced proceeds for recycling into the UK's aid programme (as the Prime Minister has promised).

Finally, there needs to be open discussion of the justification for a long-term government shareholding in CDC, and of the criteria which need to be met for public private partnership to have real meaning. The transition period should be used to demonstrate that government can continue to provide added value to CDC operations. Otherwise, it should divest fully.

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## Fifty years on...

### CDC has faced challenges before...

CDC was established in 1948 as the Colonial Development Corporation (its name was changed in 1963) to boost production of vital supplies for post-war Britain in the then-colonial territories — and thus also to hold down purchases from outside the sterling area. Huge financial resources were made available to the Corporation in the form of loans from the Exchequer – equivalent to over £2 billion in today’s money. But the Corporation was established without any equity capital: rather, CDC was simply enjoined to operate on a break-even basis. It was launched in a spirit of optimism (perhaps justified by the success of war mobilisation), and of urgency to make an early impact. In particular, there was a facile assumption that money was the limiting resource — rather than experience, know-how, or judgement.

The disasters which ensued nearly proved fatal, but Attlee’s selection of Lord Reith to lead the Corporation’s recovery in 1950 was an inspired choice. Investments were reorganised, and CDC gradually began to demonstrate a measure of success on the ground, coupled with a critically important portfolio shift towards infrastructure lending in order to stabilise revenues. However, capital reorganisation was restricted to segregating (and eventually writing off) the early lost loans, since equity capital was still taboo to the Treasury.

The winding up of Britain’s colonial empire from the late 1950s posed another potentially mortal threat to CDC, since it was debarred from making new investments in the independent Commonwealth. A view was then current in Whitehall that, with decolonisation, Britain’s responsibilities for its former territories had finished and that the United Nations and the World Bank should be the source of support for development. It took several years of lobbying — and a fortuitous good turn which CDC was able to render the Colonial Office in Kenya, when the building society movement faced collapse — before CDC’s mandate was revised.

A changed attitude towards development — indicated by establishment of a Ministry of Overseas Development, and by the landmark white paper of 1975 — confirmed a new era for CDC. Instead of being funded in relation to the Exchequer’s borrowing rate, concessional funding was introduced in the 1970s. This led to an immediate improvement in cash flow, and CDC began to accumulate reserves. By the 1980s, CDC could point to a solid record of managed projects, mostly in agriculture, but also including hotels, cement and power projects. It had a growing portfolio of infrastructure lending under government guarantee, and of lending to the private sector. At that time, UK aid policy had a clear focus on poor countries, which CDC followed, and there was much consideration of project evaluation methodology.

CDC’s financial performance was still not a particular priority. But a view emerged in the 1980s, coincident with the change of government, that CDC should be investing mainly in the private sector – albeit still predominantly through development loans. This invites comparison with the International Finance Corporation (IFC), the arm of the World Bank which invests in the private sector in developing countries. However, IFC was much more enterprising than CDC in seeking equity investment opportunities and in encouraging the emergence of local securities markets. CDC was slow to develop a culture of portfolio equity investment. Nevertheless, CDC did – and still does – have one distinctive trait in its tradition of being prepared to put management on the ground, with tropical agriculture as its strong suit. This still differentiates CDC from all other development agencies.

### Management on the ground...

A major review of CDC in 1992 by the Monopolies and Mergers Commission (which also had a remit to assess the efficiency of public bodies) validated the operational effectiveness of CDC. However, it also publicly aired questions about its future status.

The great wave of privatisations initiated by the Conservative government in the 1980s inevitably raised the question whether CDC should remain a public body, and if so on what terms. Eventually, and following a lively debate, there was a firm decision in 1993 that CDC should remain in the public sector, as an integral component of Britain's overseas development programme. Nevertheless, only four years later, in October 1997, the first privatisation decision of the new Labour government was to announce that CDC would be prepared for a new form of partial privatisation, under the banner of public-private partnership. Towards the end of last year, a new chief executive – Alan Gillespie – was hired from the City (he was formerly a managing director with Goldman Sachs), replacing Roy Reynolds, a former international oil executive. It is tempting to speculate on the chemistry of mixing a Goldman Sachs high-flier with the doyen of national development institutions; the analogy is that of pouring new wine into an old bottle. However, the truth is that CDC's culture has been changing rapidly for several years, as financial sophisticates have displaced generalists with mud on their boots, and there is a fizz of expectation about the organisation which Gillespie is well placed to exploit.

The next section of this paper seeks to explain why such a policy reversal had become compelling. Thereafter, we examine how the Labour government has sought to entrench a development mandate for CDC that will be proof against change under majority private sector ownership. The following section examines the nature of the changes that will be required in order to make CDC an attractive investment for the private sector. This prepares the ground for a concluding discussion of the measures needed to give credibility to public private partnerships in general.

All told, the next few years are going to be difficult ones for CDC. At this point, it is not clear that the Corporation can be made attractive to private investors without jeopardising its very important development mandate. Sceptics may be proved wrong; but one might ask whether (even at this late stage) there might not be a better way to achieve the same goals

## A time for decision...

Two issues lay behind the Labour government's surprising switch of policy on the ownership of CDC:

- the increasing competition for allocations under the UK's aid programme; and
- the question of whether CDC should be allowed access to external funding.

As a non-departmental public body, CDC was dependent upon the aid budget for new money to finance growth (over and above the replacement of maturing Exchequer loans and aside from the contribution from self-generated funds). Tightening public expenditure controls resulted in a progressively more uncomfortable situation, in which CDC found itself in competition with its own sponsoring department for annual allocations. Unsurprisingly, it began to lose out. Net new money made available to CDC was £49 million in 1993; there followed an announcement that it would be placed on nil net funding, which was succeeded in 1996 by the unimagined horror of having to make net repayments to government of £5 million and of £10 million in 1997. Nil net funding was restored in 1998.

**CDC at 50...**

- Gross investment portfolio of £1.5 billion invested in over 400 businesses in 55 developing countries. There are 30 country management teams based overseas.
- Regional portfolio split: Africa 29%; South Asia 28%; East Asia & Pacific 22%; Americas 21%.
- £216 million invested in managed businesses, mostly agro-business, but also including cement and power.
- CDC manages some \$230 million of third party funds in 17 country funds aggregating over \$400 million.
- Self-generated cash flow in 1998 amounted to £260 million, and new investment in that year amounted to £247 million.
- Operating surplus in 1998 £110 million, reducing to a loss of £42 million after tax and provisions in the year of the Asian crisis. Return on capital employed had been running close to 8 percent prior to this.
- The equity component of the portfolio is 30 percent; quasi-equity 8 percent and debt 62 percent.
- Accumulated reserves amount to £517 million; UK government loans to £755 million.
- Book value of equity portfolio is £342 million; the unrealised surplus value is put at an additional £99 million.

ODA's viewpoint had its own rationale: the aid budget was being "top-sliced" by Britain's multi-lateral aid commitments, at a time of crisis in the developing world and unplanned demands for emergency and humanitarian relief. There was CDC, with its strong cash flow from continuing operations; it was just too bad if its rate of new investment had to mark time for a while. To the Corporation, however, the slowdown of activity and the knock on effects on staff morale and on its reputation were deeply worrying.

One obvious way out would have been to encourage CDC to tap the loan market. Indeed, this was envisaged in its founding legislation, and was explicitly permitted in the 1986 CDC bill. Unfortunately, an unshakeable Treasury orthodoxy opposed the idea that public bodies should compete in any way with the government for funds — apparently for fear of contaminating the government's credit rating, though this is hard to take seriously since CDC would only have been in the market for around £50 million a year, borrowed and spent offshore. The hurdle put up by the Treasury was that CDC could only borrow on terms equivalent to the government, but without its guarantee. Naturally, the market recognised a distinction between the credit standing of the government and CDC, so the Corporation was effectively locked out of the market. (However, eventually it did receive some on-lending from the European Investment Bank – an international public sector institution – on terms acceptable to the Treasury.)

A ridiculous situation had been reached by the mid-1990s in which CDC had become a net contributor to the Exchequer from its operations as an arm of Britain's aid programme.

At this time, there seemed no prospect of accessing significant funds for new investment outside its own self-generated cash flow of about £250 million a year. Despite this, the Corporation's strategy was built on a widening area of operations - South Africa had just been approved, also Cuba and Vietnam; China was a prospect. All of this implied an annual growth rate of around 10 percent – clearly unachievable given the constraints implied by government policy.

## New government; new thinking

Following the change of government in May 1997, discussions began between CDC and DfID to find a way out of the deadlock. Was it conceivable that CDC could be insulated from Treasury theology by being placed formally in the private sector (with resulting access to capital markets), and yet still be dedicated to the objectives of the aid programme? Could the God of the development community be reconciled with Mammon in the City?

The outlines of a solution soon began to emerge. As envisaged, CDC would be transformed into a plc, a majority stake would be sold to private investors, and the proceeds would be recycled into additional resources for the aid programme (instead of being returned to the Treasury). CDC would be liberated financially — but only on condition that it continued to follow an investment strategy focussed on the poorer countries. If some way could be found to stop shareholders changing the Corporation’s mandate at some stage in the future, it might be possible to demonstrate a middle road between aid as charity and investment as exploitation. It might also be possible to show that economic development can be promoted in poor countries through private investors — essentially that God and Mammon can be reconciled through public private partnership.

The Prime Minister himself laid out this vision in a speech to the first Commonwealth Business Forum on October 22 1997, on the eve of the Commonwealth Heads of Government meeting in Edinburgh:

*“The Corporation has made a major contribution to Britain’s efforts to promote economic development, particularly in areas of greatest need, such as sub-Saharan Africa and South Asia. But, despite this success, I believe it is an under-utilised asset. It can do more. It has the capacity to play a much greater role in mobilising new private finance for poor countries. One of the most important developments in new Labour was the breaking down of public private barriers. I am less interested in whether an institution is public or private, than whether it works. The CDC is a public institution. I believe it can be improved by becoming a public/private partnership.*

*“I can announce that we have decided to allow the CDC to develop a new relationship with the private sector. This will require legislation to allow private investors to invest money in CDC, turning a state corporation into a partnership between the public and private sectors. Some of this money will take the form of lending and some will be equity. The Government will retain a substantial minority holding and will continue to set a framework for the Corporation’s operations in order to preserve its unique character and special skills.*

*“This new partnership will allow CDC to borrow on the capital markets. It will give the Corporation substantial extra funds each year to invest in development. I can also promise that all the money the government raises from this sale will be ploughed straight back into our development programme.”*

## CDC’s development mandate

Whenever the privatisation of CDC had been mooted in the past, it was always assumed that introduction of private shareholders would be at the expense of CDC’s developmental role. It was believed that there would inevitably be a portfolio shift to safer and more developed

## How to ensure CDC's role in development?

countries, and that “pioneering” investments, especially in the agricultural sector, would be much reduced. Indeed, how could it be otherwise in a publicly-quoted company that was obliged to maximise shareholders’ returns?

This became a particular concern for the International Development Committee of the House of Commons. As a result, the Committee took the unusual step of deciding to hold hearings on the issue even before a bill had been published, in the hope of having some influence on the outcome.

This was not a new issue. Since 1975, CDC had accepted targets for investing in poor countries (as defined by the World Bank); since 1993, the proportion has been 70 percent, with an internal target that half of its investment should be in Africa and South Asia. On pure developmental grounds, it is arguable that this proportion should increase towards 100 percent. However, this has been successfully resisted by CDC on the grounds that it should be permitted some investments in middle income countries for portfolio balance. The outcome was that the criteria for new investment (70% in poorer countries and 50% in Africa and South Asia) have now been enshrined in an Investment Policy Document which can only be changed with shareholder approval - including that of the Special Shareholder (ie. the government).

As further evidence of the government’s commitment to be a long term shareholder in a development-focussed CDC, it has also indicated in the new legislation its intention to hold not less than 25 percent of CDC’s equity (as well as the so-called Golden Share). It has also provided that this stake will not be reduced (or the Golden Share varied) without express Parliamentary approval. Unusually, the Golden Share itself is of indefinite duration.

It can be argued that a statistical definition of poorer countries is a very crude way of ensuring that CDC undertakes investments that support a poverty-focussed aid strategy, since there is no attempt to specify individual projects. That task has been left to the Board of CDC, to which the Secretary of State will nominate two directors. Furthermore, auditors will ensure compliance with the Corporation’s investment policy, and there will continue to be parliamentary scrutiny. As a result, the 70/50 split will probably work to ensure a continuing development focus.

## Were there alternatives?

At this point, it is worth reflecting on the extent to which CDC really was in a funding impasse by 1997, and to consider a possible alternative control regime, since this helps to point up more clearly the distinctive route that has actually been followed.

As a recognised arm of the British aid programme, CDC has always been exempt from taxation in most of the countries where it does business. Yet it has also been subject to UK corporate taxation. For years, CDC sought to convince the Treasury that it should be relieved of this burden, but without success. Now, following passage of the new CDC Bill, it has been given a unique tax status (so long as the government is a shareholder), under which it will not be taxed on capital gains. This might prompt the reflection that equivalent relief could have been provided at the time that CDC was being forced into making net repayments to the Exchequer; if that had been conceded, it is most unlikely that CDC would be effectively on the market today. However this would be to overlook the influence of the International Development Secretary. As was

spelled out to the International Development Committee, Clare Short was adamantly opposed to CDC re-arranging its corporate structure in order to shelter capital gains overseas, beyond the UK tax net. Instead, in a remarkable demonstration of political clout, she persuaded the Treasury to accept a unique tax status for CDC which placed it in a position comparable to that which would have prevailed if it had been able to shelter its capital gains offshore. It can, of course, be argued that CDC is not being advantaged over what a private sector company could achieve for itself by other means; but one wonders who is being fooled.

### **CDC's special role in development...**

There has often been, and perhaps remains to some extent, a degree of uncertainty as to what precisely constitutes CDC's special contribution to development.

Inspection of its investment portfolio reveals a somewhat confusing picture. There is a core of owned and managed agro-businesses in tropical forestry, palm oil, sugar, tea and the like, which is clearly "developmental"; but this only accounts for about 16 percent of the Corporation's total investment portfolio. Three quarters of the portfolio consists of loans, and there are also extensive holdings of minority equity investments. Moreover, there has been a shift in the beneficiaries of CDC investment. Over the last decade or so, for instance, there has been a growing preference for investing only in the private sector, usually through equity. Threshold criteria for acceptable projects have also been toughened, and this has recently been accompanied by more explicit recognition of environmental, health and safety and social criteria. The rule now is that CDC must be seen to be adding value when it invests and that it must promote "sustainable" businesses — as distinct from simply investing in projects.

But what does this mean in terms of defining its development mandate?

The key (at least according to Oxford's Centre for the Study of African Economies) is that CDC has the capacity to generate unusually powerful "externalities" – defined as social returns from an investment that are higher than its economic return. This arises from its focus on investing in the private sector in poor countries that have an appropriate policy environment. CDC has unique experience in assessing that environment, and this gives it a largely unchallenged comparative advantage. It has become widely accepted that the dearth of private investment is a major constraint on growth in poor countries, and this has been exacerbated by market perceptions of risk which are higher for these countries than seems warranted by their fundamental policy and resource environment. CDC is well placed to address this problem because of its 50 years of experience on the ground. In these circumstances, the social value of its investments far exceeds their private value, and this is reinforced by CDC's record as a long-term player and by the collaboration of and association with the British aid programme. CDC's almost total disengagement from public sector infrastructure investment, and its resulting concentration on the private sector in poorer counties, constitutes the core of its developmental contribution.

The pivotal role of foreign direct investment in economic development is now widely acknowledged; indeed, this is CDC's critical developmental contribution. However, it is hard to reconcile this with the aid priorities of a government which progressively undermined CDC in favour of bilateral programmes managed directly by DfID and its predecessor.

## CDC's preference was for the public sector

In the end, one has to conclude that what is happening to CDC was not inevitable; rather, it was essentially the result of a ministerial judgement that CDC was a low priority in terms of the UK's overall aid effort. This, in turn, may well have been the result of a Whitehall turf war. Certainly, CDC itself always made it clear that its preference was to remain in the public sector – albeit, provided the funding constraint could be eased.

In retrospect, the Treasury's successful rearguard action against permitting CDC to fund itself from the market, while it remained in the public sector, was a remarkable demonstration of departmental power. It has long been apparent that there was little justification for this stance. For instance, when the issue was the PSBR and the containment of inflation, it was demonstrable that CDC's expenditure was outside the UK (and therefore irrelevant), and that it would also borrow in currencies other than sterling. When the issue was comparative cost of borrowing, potential funding was sabotaged by withdrawal of the Treasury guarantee. Equally spurious (given the tiny amounts involved) was the argument that the government's credit standing would be compromised by a public sector entity paying more than the Treasury. However, new governments, new thinking; the ingenuities of the private finance initiative are now on display to underline that the real issue was always the lack of ministerial determination — either to find room for CDC in the aid budget of the mid-1990s, or to allow it access to capital markets as a public sector borrower.

Having decided on partial privatisation as the solution to the funding problem, while still wishing to entrench CDC's role as an institution committed to fostering development in poor countries, the new Labour government still had a choice as to how it should proceed. The solution adopted — a pre-defined investment policy which could only be altered with shareholder approval (including the specific approval of the government as shareholder) — was by no means the only approach. Indeed, at the time of the International Development Committee's hearings in summer 1998, an even stricter approach was contemplated. The Committee was informed at that time that the requirement for CDC to make 70 percent of its investments in poorer countries, and 50 percent in sub-Saharan Africa and South Asia, would be enshrined as part of the Articles of the new company. Changing a company's Articles entails High Court procedures — so this would have been an extraordinarily onerous way of giving expression to an investment objective which had no eternal truth embodied in it. Fortunately, by the time the Bill was published, the government's approach had changed. Now, the Articles require only that a statement of investment policy be adopted, and that shareholder approval (including that of the government shareholder) should be needed for any subsequent changes. (It is worth noting that this implies that it will not be possible for government unilaterally to impose a stricter investment objective on the company.)

## OFDEV?

It was perhaps surprising that consideration was not given to adopting the regulator model to the circumstances of CDC, given growing appreciation of its effectiveness in the utility sector. Although not currently on the table, this approach could deal effectively – and more flexibly – with the enforcement of CDC's development mandate; it could also make it unnecessary for government to retain a shareholding in the long term.

However, if a Development Regulator were to be set up — with a statutory responsibility to preserve a developmental mandate for CDC, and accountable to Parliament through the Secretary of State — it would need broad powers. In particular, it should have the power to set standards of portfolio concentration with regard to defined country and asset classes. Through regular review mechanisms, the Regulator would pass judgement on the effectiveness of these criteria as proxies for poverty alleviation, and decide whether changes should be made in the proportion of new investment going to the asset class, or to the appraisal criteria. The Regulator should

also pronounce on the effectiveness of collaboration with DfID. It would also have to be recognised that, from time to time, the goalposts might have to be moved. Conditions change; government policies change; CDC's own financial position changes.

That said, the existence of a Development Regulator would mean that the government would not have to maintain a minority shareholding in CDC, let alone its special "golden" share. This would mean that more capital could be raised for the aid programme.

There would be one other benefit. Since the City is already comfortable with the role of regulators, it would be likely to view this approach as a more reassuring way of ensuring CDC's development focus than a government shareholding and board representation – which will inevitably raise concerns about political interference in commercial decisions. As a result, CDC's share price would be likely to be higher under a regulator regime than it will be with the government as a "golden" shareholder.

## What about the investors?

The preoccupation of the International Development Committee, during its first hearings on CDC, was with the threat to the Corporation's development role, once private investors were in control. Its conclusion was that CDC was unready for privatisation, and that this should therefore be deferred until success was more assured. At this point, the Committee still had to be persuaded that a reorientation of the investment portfolio towards equity investment could be squared with CDC's developmental role. By the time of its second hearings, in spring 1999, the Committee had gained a fuller appreciation of CDC's developmental role and how it was to be entrenched. At that time, it was broadly satisfied with the proposed arrangements.

The Committee then turned its attention to whether CDC would be attractive to investors, and solicited evidence on City perceptions. However, it shied away from making an overall judgement in its report.

The problem for investors is not a simple one – though the existence of a transition period between passage of the legislation and the sale of shares provides an opportunity to address investor concerns. In particular, four aspects of CDC's situation need to be recognised:

- the initial perception of CDC's concentration on high risk markets;
- problems in interpreting CDC's financial record (and the extent to which it is a guide to the future);
- issues relating to its new structure and key performance indicators; and, finally
- issues relating to the government's continuing involvement with CDC.

## Risk...

The elaborate arrangements made to entrench CDC's development mandate, and to ensure that this cannot be altered without government approval, have had the unintended (but inevitable) effect of emphasising the possibility of conflict between private and public investors. In particular, the requirement to make 70 percent of new investments in poor countries (and 50 percent in sub-Saharan Africa and South Asia) is equated with high risk: it seems to imply both that such countries will not provide an economic environment which is conducive to successful business investment, and that there is a high political risk of interference with foreign investors.

One investor response will be to require a higher rate of return than would be expected from a comparable company operating in perceived safer markets. Disproving this is, of course, at the heart of CDC's developmental role. To impress investors, CDC has to demonstrate that it can meet its development mandate and earn commercially attractive returns while doing so.

## Track record...

Here, there is an immediate difficulty. Traditionally, CDC's statutory responsibility has been to break even, taking one year with another — which was scarcely demanding. From the early 1990s, a financial target was agreed of a pretax return of eight percent on total capital employed (government loans and reserves), expressed as a moving average of three years. Again, this was not a very onerous target. But, for ODA, the real focus was on the financing of CDC's investment programme, and the extent to which self-generated funds needed to be supplemented by allocations from the aid budget. There was no performance measure that could be related to shareholder value, and there was no incentive to improve the return on total capital employed (other than enhancing self-generated funds for investment).

The Monopolies and Mergers Commission had raised the issue of introducing public dividend capital into CDC in its 1992 report; but, at that time, the government saw no need to reorganise the Corporation's finances. With government as the only, limited, source of new money, CDC was unable to evolve into a development bank, although much of its new business was of this nature.

By the mid-1990s, its investment capacity was consistently greater than the volume of business it was actually permitted to undertake, which was a cause of considerable management frustration. This was especially true for large-scale loans to private sector projects in power generation and transport. In the 1998 balance sheet, total government loans, at £750 million, were only 1.5 times the Corporation's reserves. Even IFC, with its triple A investment rating, is permitted to borrow four times equity. This may be taken as a crude measure of the extent to which CDC was held below its potential by the government-only loan funding policy.

That said, CDC has always been an equity investor. Initially, this was in projects managed by the Corporation, but it was always willing to consider equity participations in conjunction with loan financing. Likewise, there is a long history of equity realisations when CDC's loans matured. The value of this equity portfolio, however, has been masked by an accounting policy which showed investments at cost (less any provisions), rather than applying a market value to them. From the late 1980s, this meant that CDC was able to spring a string of surprises from realisations, which contributed significantly to cash flow in some years: 23 percent in 1992, 32 percent in 1996, but only five percent in 1994. What has not been clear to the outside world is the extent to which CDC is capable of producing a consistent flow of equity realisations to enhance its financial performance, in the manner of a venture capital business such as 3i. If it is to do this, the starting point will have to be a change in accounting policy to bring equity values into the balance sheet, accompanied by a clear strategy concerning realisations. (The 1998 annual report indicated that CDC was carrying approximately £100 million of unrealised equity value.)

The other big question mark is whether CDC can earn returns that are acceptable to the market from its equity investments. True, CDC has been increasing its investment appraisal threshold over the past decade towards financial hurdle rates of 20 percent or more. However, with three quarters of its assets in the form of loans, performance of the underlying businesses

in which it has invested has been masked in CDC's own accounts. This failure to capture the results of its own experiences in emerging markets is the principal explanation for CDC's modest financial results to date, and the reason why a simple examination of its financial record is not necessarily a reliable guide to a future that will be dictated by different management objectives.

This point is worth dwelling on. If an investment proposal is appraised to show a financial rate of return in excess of 20 percentage points, but CDC only invests through a loan with a margin of five percent, the difference flows through to the equity owners of the project. The development externalities are still achieved, and domestic and foreign direct investors are well incentivised. To the extent that CDC's own financial performance becomes a key indicator of the risk/reward benefit of investing in poor countries, it will be essential to obtain for the Corporation an equity return commensurate with other investors.

## New structure...

This brings us to the question of CDC's future capital structure and key performance indicators.

In evidence to the International Development Committee, it was emphasised that CDC's capital should be reorganised immediately after passage of the Bill, in order to establish a track record prior to any sell-off. This has been accepted. The 1999 CDC accounts will be closed in their traditional form; but the Corporation's capital will be reorganised early in the new year so that the published accounts will also contain a *pro forma* for the new balance sheet structure. Thus 2000 will be the first year for the re-invented CDC.

The decisions over the new structure have yet to be revealed. In 1998, more than half of CDC's new investments were in the form of loans. If its business were to remain in investment banking mode, the reorganisation of the balance sheet for private investors would suggest loan gearing of about four times, to produce a structure comparable with IFC. However, given the intention to transform the portfolio substantially towards equity and profit sharing assets, there will be a concomitant need to reduce gearing and to create a structure which is comparable to a venture capital company, so leverage may be nearer to one to one.

Compared with its previously published return on total capital, CDC will now be able to show a return calculated on its new equity base, and with the benefit of whatever gearing is finally decided upon. It will be surprising if this does not straightaway produce a better return. But the principal challenge will be to increase the intrinsic profitability of the investment portfolio to CDC. The critical change will be to move away from lending to businesses towards investing in them, on a shared risk and reward basis.

This will not be simple. In many countries, the perception of CDC is still of a loan institution which has the capability to complete the financing of projects, beyond the capacity of the equity owners. In effect, what has been happening is that CDC has assisted in the completion of projects with high rates of financial and economic returns, but has limited its own reward to that of a margin on loan funds – albeit well secured. A new perception of CDC as a reward sharer has to be established in these countries, which will take time. Within CDC itself, new skills and techniques will also have to be developed, consistent with this move towards venture capital investment. All this implies a major cultural change within the Corporation, — which, to be fair, is already underway.

The switch to an accounting regime showing total returns, including unrealised capital gains, also has an implication for CDC's culture. It will mean there will be greater emphasis on the time

horizon of investments in the portfolio. In many emerging markets, where capital market transactions are still something of a novelty, devising exit strategies will be a significant test of CDC's skills and country know-how. As 3i and venture funds have shown, the ability to sustain a flow of realisation proceeds is a major component of investor credibility.

Apart from the main portfolio held in CDC Investments, there are two other divisions of CDC's operations which raise different issues for investors.

With CDC Industries, where over £200 million is invested in managed businesses, good progress has recently been made in transforming the portfolio into a group of enterprises which can hold their own on a global scale. The time scale of the venture capitalist does not apply here, and CDC will seek to demonstrate that satisfactory rewards can be earned from ownership and management of tropical commodity exports on a long term basis. Already the picture is not unsatisfactory. By 1988, CDC had invested £216 million in 30 businesses in its Industries portfolio. Their total pre-tax profits amounted to £46 million, and CDC's share was £17 million. However, the overall return was still a modest eight percent. The managed businesses are important in terms of development value, since significant export industries have been created from scratch in palm oil, sugar, fruit juices, and plantation forestry. They are also important in terms of quality of earnings and capital values, in comparison with portfolio revenues. There is a danger, however, that short-termism may lead to a temptation to harvest such investments and not to replace them with new long maturing ventures.

CDC Financial Markets represents an important enhancement to CDC's earnings profile as a fee-earning activity. With £140 million under management in 1998, a start has been made in managing venture capital funds for other institutional investors. This plays well to CDC's reputation for special expertise in pre-emerging market situations, which now needs to be reinforced by a track record and a larger scale of operations.

## Investor perceptions...

Official spokesmen have been adamant that CDC will not be brought to market until the timing is right, and there was no quarrel with the argument put to the International Development Committee that a transition period of at least four years might be required.

We have noted the challenge of replacing a £1.6 billion loan portfolio by higher earning assets, and the internal and external cultural problems associated with such a change. A big question for the future is the extent to which CDC's balance sheet will be taken at face value when shares are sold, or whether the market will apply a discount to it. There is also likely to be sensitivity from the government side that there should be no undue 'give-away' in relation to the float. Undoubtedly, CDC - in its new form - must have sufficient time to demonstrate improved financial performance from the very low base of 1998 and 1999.

It is also probable that the government's intention to retain a significant minority shareholding in CDC, and to nominate two directors, will detract from the company's value - in particular, compared with a complete disposal and the establishment of a regulatory regime. The perception will be that government has reserved the right to intervene in the affairs of CDC. For example, it will be felt that political objections might be raised to stop CDC reducing the number of its offices, or the countries it invests in. There might also be concerns about the leverage of aid or environmental lobbies through DfID. The investment banking advisers involved will have been weighing up the prospects and sounding out the appetite of institutions for CDC paper. It

seems clear that reliance should not be placed on ethical investment funds to solve the problem of investor support. The case made to institutions for portfolio diversification to take in CDC as a proxy for emerging markets will have to be firmly grounded on CDC achieving investment returns which reflect perceived risk and on the prospects for value enhancement of its equity investments. Although CDC can point to individual success stories from its record to date, this has yet to be reflected in overall portfolio performance.

Taken together, these factors will predispose the market to discount CDC shares compared with a wholly private business operating with the same objectives. Is there any possibility that such a negative attitude could be overturned through the magic of public-private partnership?

## Public-private partnership...

The government plans to retain indefinitely a minority shareholding in CDC.

From the point of view of CDC's rating, the presence of a government shareholding (and golden share) is likely to be regarded as a negative. There will be a presumption that CDC is not its own master on sensitive issues such as the timing of realisations and new investments, portfolio priorities, the resolution of disputes etc. Furthermore, the golden share will be interpreted as easing pressure on management to focus on shareholder interests and as removing a powerful incentive to perform.

Against this, it could reasonably be argued that CDC's status as a public corporation has undoubtedly been beneficial to it in the eyes of many developing countries, and that a continuing government shareholding should preserve much of this advantage. In many countries where foreign direct investment has been regarded with suspicion, CDC is seen as being different and more welcome, which has eased the path for collaborative investment. This was particularly true when many African countries were endeavouring to reschedule debts to the private sector. CDC never joined the London Club, and was able instead to renegotiate loans directly with governments — often finding imaginative solutions involving the reinvestment of repayment proceeds.

In my opinion, what this suggests is that the market will consider a continuing government stake in CDC to be a negative influence, unless there are clearly perceived benefits from such a special relationship. How might one ensure that a government shareholding imparts added-value to CDC, and that the notion of public-private partnership has a positive meaning?

Officials are at pains to emphasise that public-private partnership must not mean providing subsidies for the benefit of private investors. This must be taken seriously. Indeed, the European Commission's competition authorities will have to be satisfied about the initial capital structure of CDC and its unique tax status.

How does one tackle this? In the case of CDC, the starting point must be the tough development mandate which has been written into its new Articles of Association (through the statement of investment policy). This surely scotches any suggestion of unfair advantage to investors in CDC, or to CDC itself, as against other investing institutions.

## Adding value

We turn now to the question of how the government's minority share might be seen to add value to CDC. Four possible avenues are explored. They all entail a change of stance towards CDC on the part of DfID – and an increase in collaboration.

## Making government intervention into a positive for investors

### Technical assistance...

In many ways, the easiest area of collaboration with DfID, and one in which there is a spasmodic history of past support, is that of technical assistance to CDC projects. This would have to meet two obvious conditions:

- first, that other organisations could also qualify (in principle) for similar support; and
- second, that DfID's support would need to benefit CDC by relieving it of costs it might otherwise have incurred.

To qualify for the UK aid budget, this technical assistance through DfID must also convey benefits to the developing country. Examples might include:

- Technical and management training for staff employed on a project, especially to reduce expatriate costs. This might also extend to assistance in complementary areas, such as utilities privatisation, or government agricultural services to small farmers.
- Pre-investment grants towards the cost of feasibility studies and pilot tests. This is a heavy overhead cost at CDC since many appraisals do not lead to projects. Another area of potential collaboration is the cost of assessing environmental and social issues.

### Helping the balance sheet...

The biggest challenge facing the new CDC will be to transform its investment portfolio from one dominated by loans to one characterised by equity-related returns. Waiting for loans to mature and be replaced by new assets implies an extended time scale, given a loan portfolio with an average life of about seven years. There is also the issue of slow-maturing greenfield investments - notably forestry and tropical tree crops. How could DfID be a more pro-active shareholder here? Three possibilities appear worth investigation:

- DfID could purchase (with privatisation proceeds, so as not to impinge on existing programmes) a portfolio of CDC loans and hold them to maturity, retaining a modest fee out of the interest received and leaving the balance to CDC. This would have the effect of accelerating CDC's cash flow for investment, as well as generating fee income to enhance the return on capital.
- In respect of new greenfield projects, where CDC is the majority (or only) shareholder, the investment could be placed with DfID for an initial period with a put option back to CDC, which would thus bear the investment risk. CDC would receive a fee for managing the project.
- Certain DfID activities could be offered on to CDC as an agent. Examples might relate to disbursements under DfID's bilateral programmes for capital grants, and in the management of revolving funds directed at the private sector.

It is easy to anticipate objections to any or all of these proposals, on the lines that they would unfairly privilege private sector shareholders in CDC. Doubtless, such objections would be raised. But a little reflection shows them to be without much substance. Given CDC's investment focus, the need to lower the risk threshold of projects in the poor countries and the desirability of accelerating CDC's ability to reinvest in new projects, it should not be any more difficult to defend applying DfID resources in this way than it is to defend improvements to the private sector environment by making aid grants for specific posts, power supplies or communications.

## Coordinated development...

The bilateral aid programme could also be deliberately moulded to achieve complementarity between CDC initiatives in the private sector and related social infrastructure projects, both to maximise overall impact and to relieve CDC from infrastructure expenditures in remote areas. This could apply to forestry, mining, smallholder agriculture and plantation development. A related idea would be to develop coordinated sector strategies, eg in power generation or water resources — with the aid programme focussing on distribution networks to complement central facilities developed by CDC.

A continuing government shareholding in CDC should mean a shared interest in diminishing the perceived risk of investment in poor countries — and hence a shared interest in maximising the continued impact of grant aid and CDC investment. However, this can be hard to put into practise. Aid officials primarily deal with government officials and the developmental priorities of that government, no matter how pro-active the donor tries to be in identifying projects. For their part, CDC representatives will be looking for profitable investments in the private sector. This means that DfID and CDC will need to develop shared country strategies if they are not to miss the opportunity of mutual reinforcement. With the wisdom of hindsight, one might point to the absence of a coordinated strategy between CDC, the aid programme and food trade policy in respect of eastern Caribbean bananas. During half a century of protected imports and with the leverage available from aid programmes and investment, Britain failed to prepare these islands to meet achievable standards of production needed for such a globally traded commodity.

## Conclusion

It may be that the idea of the UK government using its shareholding to add value to CDC is pie-in-the-sky. It may be unrealistic to think of coordinating aid strategy with CDC's own investment programme. It may even be politically impossible to achieve this level of co-operation. But, if that is the case, what then? If there are no obvious benefits to be gained from the government's shareholding in CDC, then the public interest would be better served by disposing of the entire shareholding – relying on CDC's Articles (and, even better, a regulator) to ensure that it continues to focus on poor countries. In that case, it is quite likely that the market's opinion of CDC's prospects would actually rise quite sharply. After all, the real prize - in terms of Britain's policy objectives for international development - is that CDC should be as effective as possible as a catalyst for private capital flows to poorer developing countries, and that CDC should be a living demonstration that successful businesses can be fostered in these countries, whether by investing in local entrepreneurs, co-investing with external investors, or undertaking greenfield projects of its own.

During the several years in which CDC will remain as a wholly government-owned plc, every effort should be made to test the assumption that there is added value in the government's retained shareholding. Experiments can be made – and reversed if unsuccessful. If the magic of synergy can be demonstrated, there can be general satisfaction. By moving into a minority shareholder position, the government will have removed the major obstacle to CDC obtaining access to adequate funding. But if the government is unable to add demonstrable value as a minority shareholder, it may also be that CDC would have a better market rating and better prospects with complete official disinvestment, so that it was clearly seen to be beyond the reach of Victoria Street. In such circumstances, government should then be encouraged to proceed – in one or more stages – to divest itself of its half-century ownership of CDC, so that it can recycle the full value of that investment into an enhanced bilateral aid programme.

**This may  
not be  
the  
end of the  
story...**



*Sir Michael McWilliam is chairman of the Royal Commonwealth Society and of The Royal African Society. He was a member of the Board of CDC from 1989-96. His earlier career was with Standard Chartered, where he became its chief executive. He was subsequently director of the School of Oriental and African Studies. He is currently engaged on writing the history of CDC.*

#### Notes

1. The story of the first 25 years of CDC has been narrated by its first general manager, Sir William Rendell: *The History of the Commonwealth Development Corporation 1948-1972* Heineman 1976. See also the Monopolies and Mergers Commission's report *Commonwealth Development Corporation* HMSO Cm1983 1992
2. The International Development Committee of the House of Commons has held two hearings on the privatisation of CDC. Its reports, together with written evidence and committee hearings are published as: *The Future of the Commonwealth Development Corporation.* Eighth Report of the International Development Committee, Session 1997-98. HC 936. Stationary Office July 1999. *The Provisions of the Commonwealth Development Corporation Bill.* Second Report of the International Development Committee, Session 1998-99. HC212. Stationary Office April 1999.
3. The government's responses to the two reports were published as: *Government Response to the Eighth Report from the Committee Session 1997-98*. Stationary Office HC1100. 1998; and *Government Response to the Second Report from the Committee Session 1998-99*. Stationary Office 604. 1999.
4. See also two review articles on the above reports by the author: *The Future of the Commonwealth Development Corporation* in The Round Table, No 349 Jan.1999; and *Satisfying the God of the Development Community and Mammon in the City* in The Round Table, No 351 July 1999.

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2. **"Derivatives for the retail client"**: A proposal to permit retail investors access to the risk management aspects of financial derivatives, currently available only at the wholesale level. by Andrew Dobson. Nov 1993 (Only photostat available) £10/\$15
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