

Privatizing the English National Health Service

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Behind The Jargon

Privatizing the English National Health Service: an irregular verb?

Abstract

This article explores different stakeholder perspectives of “privatization” in the English National Health Service (NHS). Much of the academic literature makes empirical claims about privatization on the basis of absent or shaky definitions of the term, resulting in much of the debate on this issue largely being a “nondebate”, where opponents talk past rather than to each other. We aim to throw light on privatization by applying the lens of the “three-dimensional” approach (ownership, finance, and regulation) of the mixed economy of welfare to the views of key voices within these debates. These stakeholder perspectives are political (parliamentary debates), public (opinion polls), clinical provider (British Medical Association and Royal College of Nursing), and campaigning groups. We argue that in terms of grammar, *privatize* seems to be an irregular verb: I want more private sector involvement: you wish to privatize the NHS. The term *privatization* is multidimensional, and definitions and operationalizations of the term are often implicit, unclear, and conflicting, resulting in conflicting accounts of the occurrence, chronology, and degree of privatization in the NHS. Stakeholders have divergent interests, and they use “privatization” as a means to express them, resulting in a Tower of Babel.

Introduction

This article explores different stakeholder perspectives of ‘privatization’ in the English National Health Service (NHS)¹. It is a ‘public health service’ or ‘Beveridge’ model which is largely publicly funded and provided (Maarse 2006), although some commentators regard it as an international ‘leader’ in privatization (eg Pollock 2005: 18). Much of the academic literature also makes empirical claims about privatization on the basis of absent or shaky definitions of the term, perhaps believing its meaning to be so clear as to not need a full explanation. At one end of the spectrum there are narrow, ‘one dimensional’ definitions that focus on the transfer of assets. Dunleavy (1986: 13) defines ‘privatization’ strictly as the permanent transferring of service or goods production activities previously carried out by public service bureaucracies to private firms or to other forms of non-public organizations. Other commentators take a broader perspective. According to Le Grand and Robinson (1984), privatization involves a reduction in state activity in one of the areas of provision, subsidy and regulation. Young (1986) argues that seven different forms of privatization were identifiable in policies of the British Conservative government in the 1980’s, including the extension of private sector practices into the public sector and reduced subsidies and increased charging.

Much of the debate on this issue therefore has largely been a ‘non debate’, where opponents talk past rather than to each other. It tends to generate more heat than light as definitions and operationalizations of ‘privatization’ are often implicit, unclear and

¹ Responsibility for planning and delivery of publicly funded healthcare in the UK has been progressively devolved to the constituent nations, meaning that in many respects there is no UK NHS as such but rather different NHSs in England, Scotland, Wales and Northern-Ireland

conflicting (cf Maarse 2006), and the term tends to be a general ‘boo word’ that lacks definitional and analytical precision, and is often conflated with other terms such as ‘marketisation’.

Maarse (2006) examines privatization from four different perspectives: financing, provision, management and operations and investment. However, we provide a three dimensional account which examines movement between origin and destination cells in a 16 cell model. The basic model differentiates between state, market, voluntary and informal provision/ownership and finance. The third dimension, of state regulation, is indicated by inclusion of an H (high) and L (low). In line with the common elements of definitions outlined above, extreme privatization would entail movement from Cell 1H (i.e. state funding and provision) with high regulation (through hierarchical power as there would only be public sector provision) to that of Cell 6L (i.e. market funding and provision) with low regulation. Table 1 provides examples from the different periods of the NHS (see eg Keen et al 2001; Maarse 2006; Powell 2008).

We aim to throw light on privatization by applying the lens of ‘three dimensional’ approach of the Mixed Economy of Welfare (MEW) (Powell 2007, 2008) to the views of key voices within these debates.

Privatization and the English NHS: Stakeholder Perspectives

Political Perspectives

While privatizing state assets in fields such as utilities may have been ‘official’ policy, no English government has ever stated that it wishes to ‘privatize the NHS’. However, previous Conservative (1979-97) and Labour (1997-2010) governments saw a greater role for the private sector, and all major parties supported this in the 2010 election (Timmins 2012). The contentious nature of this discussion was highlighted in a parliamentary debate on the new Health and Social Care Act (House of Commons 2012). The Labour opposition spokesperson recognised that ‘there is an important role for the private sector in supporting the delivery of NHS care’, but noted with concern plans to open up the NHS as a regulated market, encourage private sector involvement in both commissioning and provision of NHS services (Cell 2); and increase the private income cap for NHS hospitals to 49% (Cell 5). Describing the proposals as a break with 63 years of NHS history and a “genie out of the bottle” moment, he contrasted with an interpretation of the previous Labour government’s policy to ‘use the private sector at the margins to support the public NHS’. Critics argue that greater private involvement risks putting profits before the interests of NHS patients, stressing issues such as ‘cherry picking’ or ‘cream skimming’, and conflicts of interest between shareholders and patients.

In response, the government spokesperson reflected that when in power Labour had contracted with ‘Independent Sector Treatment Centres’ delivered by private companies (Cell 2), and stated that they wished to increase the role of the private sector to 10% or 15% (Cell 2). From this perspective the new Bill was simply an ‘evolution’ of previous government policy. He argued that giving patients choice of private or public providers did not represent a forced externalisation by the government as it as patients would decide, and concluded that if the values of the

NHS remained unchanged then the NHS could not be said to have been privatised – ‘no NHS patient pays for their care today; no patient will pay for their care in future under this Government’. Supporters argue that any private income earned by the NHS private income will be ploughed back into benefits for NHS patients.

This debate highlights that there is political agreement around moving the NHS towards Cells 2 and 5 and therefore all parties could be ‘accused’ of privatising to some extent. Alleged areas of difference relate to a somewhat arbitrary and changeable boundary around an acceptable level and type of private involvement, and the extent to which a continuation of the principle of ‘free access based on clinical need’ results in a ‘public NHS’ (even if through patient choice clinical services are largely delivered by the private sector).

Public Perspectives

There is no doubt of the strength of public feeling in favour of the ‘principles’ of the NHS, but views on delivery, particularly the extent to which aims might be achieved through private means, are less clear (Dean 2001). Opinion polls do suggest a degree of concern regarding the role of the private sector – for instance Ipsos Mori’s survey of over 1000 people (2012) found that 70% of those who mention it as a change being made to the NHS believe it will make services worse for patients (up 10 percentage points from December 2011) and Gattleson’s on-line survey of 2,200 respondents (2011) found that 71% opposed (and 7% supported) a ‘full privatisation’ of the NHS. Asked about the move to give patients choice of provider from any sector (i.e. removing the public sector monopoly) the numbers were a lot closer however, with 31% in support and 38% opposed. Similarly a Populus (2011) survey reports that 74% agreed that ‘the most important thing is to have high quality, free, public services - not who is involved behind the scenes in running them’. Wellings et al (2011) write that two in five do not mind who provides health services as long as they are free of charge, although some surveys report that the public are wary of the ‘profit motive’. This rather mixed picture suggests that the public appear to reject ‘full privatisation’. However, this is not defined, and they appear to be against ‘commodification’ (charging) more than plurality of supply. In other words, public views on ‘privatisation’ may vary on different types of the term and indeed on how survey questions are phrased (cf Dean 2001).

Clinical Perspectives

Two of the most prominent professional bodies are the British Medical Association (BMA) and the Royal College of Nursing (RCN). Both act as trade unions and representative bodies and were in existence long before the NHS (and therefore concerns regarding privatisation) was created (175 and 97 years respectively). Whilst much of their membership is drawn from public sector employees, there are also a significant proportion of nurses who work in the independent sector, and consultants who undertake private work alongside their NHS duties. Furthermore GPs, who are the traditional ‘backbone’ of the BMA, effectively work as self-employed independent contractors to the NHS.

Whilst the RCN describe itself as not ‘ideologically opposed’ to involvement of the private sector in the NHS, it does not support (undefined) ‘whole scale privatisation’ (RCN 2007). It remains ‘strongly committed’ to a ‘publicly funded services which is

free at the point of delivery' (RCN 2012), which is rather similar to the government's stated position. It states a pragmatic or evidence-based rather than an ideological opposition, using the example of ISTC as an example of 'contracting out' to the private sector which is not working in practice.

The BMA has been more vocal in its opposition to increased private sector involvement (Timmins 2012). Its 'Caring for the NHS' initiative in 2008 involved leaflets being delivered to every GP practice in England which stressed the importance of public health care services being funded through general taxation (the top row of the MEW). In the accompanying policy statement it saw only a 'peripheral' role for private sector provision and this view was reinstated in the response to the current changes (BMA 2010). Once again there is no clear definition of what constitutes 'peripheral'. Moreover, there is a refusal to recognise that GPs have been de facto 'private sector providers' since 1948.

The dual role of these organisations gives rise to some problems in specifying organisational interests. Arguments against privatization are often made with respect to protecting standards in a public service, but critics claim this may be hiding self-interest in the form of maintaining national pay deals, avoiding competition, and blocking change.

Campaigning Group Perspectives

Such is the strength of passion for a 'public' NHS that a number of campaigning groups have arisen to protest against any further 'privatization'. These include 'Keep Our NHS Public' (KONP) (a 'grass roots coalition' of 'medical professionals', unions, user groups and 'concerned citizens'), the NHS Support Federation (NSF) (drawn 'equally' from 'health professionals' and the 'general public) and National Health Action (NHA) (a new political party launched by doctors with a manifesto to specifically challenge 'privatization'). KONP (2012) describe private sector involvement as 'destabilising in the short-term and highly damaging in the long-term' due to a 'fragmentation' of the risk-pool, 'marketization' in which providers maximise profit through payment for activity mechanisms, and 'disintegration' of the current public provision. They also raise concerns regarding a loss both of public accountability and interest in preventative measures. Under the banner of 'private sector involvement' they incorporate not only who funds and delivers but also the payment mechanisms and how these might influence all providers, including NHS. The MEW is not of use in this regard as such mechanisms are not traditionally considered in its three dimensions.

NSF also take a holistic view of 'privatisation' that incorporates the removal of the 'income cap' for NHS providers outline above and franchising of the management of NHS resources (NSF 2012). Both NSF and KONP include a greater role for not-for profit providers under the banner of privatisation, with concerns that whilst this would 'hike up' administration costs and reduce flexibility available to commissioners (as in their view external services would only work to the letter of their contract whereas internal provision are seen as being more responsive). This includes charities, which under English law must be set up for 'public benefit' and be overseen by volunteer trustees who do not receive financial reward from the organisation. NSF view one of the UK's largest health charities as operating as 'any other corporate entity' despite

reinvesting all their profits back into patient services. This suggests an interpretation of 'private' that is essentially anything other than those services traditionally run by and contracted with the NHS and therefore outside of MEW Cell 1. Once again GPs are not included in the private sector, with their surplus being described as a 'salary' rather than as 'profits' (KONP 2012).

An Irregular Verb?

As expected, applying the MEW highlights that there is not a commonly used definition of 'privatization' among the stakeholders, and they will adapt and bend the definition depending on their starting point and assumptions. Second, there are some protests against (an undefined) 'full' privatization when it is unlikely that this is an option (cf Timmins 2012: 99). For some, the issue appears to be over principle, but for others it is more about pragmatism or evidence (although the evidence is sometimes flawed or absent). The 'bottom line' appears to be the 'free at the point of use' principle (ie cell 14 commodification) for some, although the NHS has arguably never been fully free at the point of use. For others, the issue appears to be one of degree rather than principle, but it is unclear where the 'line' should be drawn. For example, there was heady talk during the Labour government that 15% or more of NHS waiting-list type treatments could one day be provided by the private sector, although the proportion in fact has yet to reach 5% (Timmins 2012). There is no clear explanation of why, say, a Trust could receive 30% but not 49% of its income from private patients. Finally, there seems to be some 'forgotten pasts' or 'dogs that did not bark' as Labour politicians attempt to avoid past 'privatizations' that they have introduced and some 'independent contractors' are seen as more equal than others. In terms of grammar, 'privatize' seems to be an irregular verb: I want more private sector involvement; you wish to privatise the NHS.

The term "privatization" is multi-dimensional, and definitions and operationalizations of the term are often implicit, unclear and conflicting, resulting in conflicting accounts of the occurrence, chronology and degree of privatization in the NHS. Stakeholders have divergent interests, and they use "privatization" as a means to express them. Unfortunately, the result is a tower of babel.

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Table 1 The Mixed Economy of Welfare in the British NHS

| | State provision | Market Provision | Voluntary Provision | Informal Provision |
|-------------------|---|--|--|---|
| State Finance | (1) NHS Hospitals (1) General Practitioners (1-4)? NHS Trusts (2) Foundation Trusts? (3-4) CHI/ HCC/ CQC (High regulation) (3-4) (High regulation) Monitor (H) (3-4) | (2) General Practitioners (1-4)? Hospital Cleaning (2-4) Independent Sector Treatment Centres (3-4) Contracting with private hospitals (2-4) Private Finance Initiative (2-4) Private Consultancies (3-4) Tendering of management of NHS Trust management (3-4) | (3) Contracting with mental health charities (1-4) Foundation Trusts? (3-4) Right to Request (3-4); AWP / AQP (3-4) Hospices (2-4) | (4) Personal health budgets (3-4) |
| Market Finance | (5) Private health beds in NHS Hospitals (1-4) | (6) Private health care funded by private insurance (1-4) | (7) | (8) |
| Voluntary Finance | (9) | (10) | (11) Hospices (2-4) | (12) |
| Informal Finance | (13) Pay beds in NHS Hospitals(1-4) | (14) Prescription charges (1-4); Spectacles (1-4) Dental examination (2-4); Optical examination (2-4); OTC Medicines (1-4); Private medicine (1-4); | (15) | (16) |

Periods: ‘Classic NHS’ (1948-79) = 1; Conservative (1979-1997) = 2; New Labour (1997-2010) = 3; Coalition (2010-) = 4.