What are the costs of privatisation in the UK's healthcare system?
Link here.

Teaser:

Privatisation of the NHS has come in many guises over the last decade. This has had its costs – not least fragmentation, waste, loss of patients' trust, inequities in access, the creation of a self-seeking for-profit service sector and the potential emergence of a two-tier healthcare system.

Main text:

Privatisation of the NHS features regularly in the news, including debate over whether it will increase capacity or lead to a fall in standards of care. Various healthcare policy reforms have also led to discussions of the dangers of the NHS being undermined by privatisation.

This article examines different forms of privatisation in the UK's healthcare system – one that is funded primarily through public taxation – and assesses the social costs of these developments.

Privatisation is a nebulous and multidimensional concept (Exworthy et al, 2023). This makes an accurate assessment of the extent of privatisation in the NHS, and its impact, challenging. For the purposes of this article, privatisation is defined as policies that restrict the role of the public sector and increase that of the private sector (Le Grand and Robinson, 1984).

Marketisation – a policy favoured by recent governments in Westminster – is sometimes claimed to be a form of privatisation. It is characterised as being when the NHS does not leave the public sector but moves to a more market-like environment emphasising choice and competition. Some have argued that this approach is beneficial as it enhances quality and efficiency.

Is there evidence of significant privatisation in the NHS?

It has been argued that the principles of the NHS have been undermined by a string of reforms over recent years, such as the Health and Social Care Act 2012 with its particular emphasis on marketisation. Others claim that this is overstated (Iliffe and Bourne, 2021).

Yet overall, it does appear that 'creeping' privatisation and marketisation of the NHS have occurred.

One evident form of privatisation is the use of NHS funding for private provision. For example, the proportion of the NHS budget spent on private providers rose from 3.9% in 2008/09 to 7.3% in 2018/19 (Iacobucci, 2019).

The Centre for Health and the Public Interest (CHPI) suggests that this is a significant underestimate. Its analysis includes further spending, such as that by

local authorities, charities, the voluntary sector and social care, in its estimates, which suggest that the proportion of the NHS budget spent on private providers is at least 18%.

The CHPI also changes the denominator to the total expenditure of NHS England rather than that of the Department of Health and Social Care, which it argues includes funding of regulatory bodies and the expense of running the department itself (Iacobucci, 2019).

The government's policy response to the Covid-19 pandemic once again reflected the move towards a public-private partnership (Calnan and Douglass, 2022). This was highlighted by considerable public investment in the private sector, for example, through the outsourcing of the problematic test and trace system, which cost an estimated £16 billion (Charlesworth et al, 2023).

The impact of outsourcing of health and social care services to the private sector is variable. In some cases, it can also be damaging, such as resulting in a failure to fulfil contracts to build hospitals or to provide out-of-hours care (Sasse et al, 2019).

But overall, it does not appear that a significant share of NHS services have been taken over by the private sector (Holmes, 2023). This suggests that a two-tier system is unlikely because of the limited capacity of the private sector (Anderson and Mossialos, 2022).

This is partly due to the lack of a developed private market. There are a limited number of private providers, and they tend to cherry-pick the types of services that do not deal with patients with complex needs, such as physiotherapy, where profits can be generated quickly (Krachler and Greer, 2015; Bayliss, 2022).

The different forms and processes of privatisation have costs. For example, marketisation has shown limited benefits in terms of quality of care, including through policies aimed at providing patients with more choice (Calnan, 2020).

Marketisation has also led to fragmentation as organisations found it difficult to work together to join up services, and to the wasteful delivery of services as bidding for contracts involves substantial expenditure (Iacobucci, 2021).

This, in turn, has led to a policy shift towards the prioritisation of integrated care systems in the most recent reforms, the Health and Care Act 2022 (Powell, 2023). These emphasise co-operation rather than competition.

In July 2022, 42 integrated care systems governed by integrated care boards and partnerships replaced clinical commissioning groups throughout England with a view to enhancing integration between NHS providers, local government and other providers (Powell, 2023).

Despite the emphasis in this legislation on cooperation rather than competition, there is some debate about how far these integrated care systems might facilitate further, larger-scale privatisation, for example, through the procurement process and the influence of private providers on decision-making.

Whether these concerns materialise will become more evident when the reforms in the Health and Care Act 2022 are fully implemented across the country (Dayan and Buckingham, 2021).

Yet, rather than traditional privatisation, it has been argued that the health system is facing a more subtle and harmful erosion of public services across different areas, which could continue despite the nationwide introduction of integrated care systems (Bayliss, 2022).

It is argued that this comes as a result of what is seen as a politically influential and self-seeking for-profit private sector, with private equity ownership and aggressive marketing, that has evolved alongside a chronically underfunded public system, weakened further by the pandemic.

Private financial investors are now integrated into some segments of healthcare delivery, particularly mental health services (Bayliss, 2022). The increasing digitalisation of healthcare has also provided an entry point for a number of US private companies (Armstrong, 2023).

The commercialisation of healthcare also has costs for doctors and patients. For doctors, it can lead to pressure to compromise their altruistic and public sector values (Castellani and Wear, 2000). An increased emphasis on corporate values and on enhancing the organisation's income can lead to treatments that may be against the best interests of patients (what is sometimes called 'supply-induced demand').

Commercialisation of healthcare is also associated with a lack of patient trust where uncertainties about the integrity of the provider can create barriers to consultation. In addition, it can lead to a lack of patient adherence or disclosure of information, which can affect healthcare outcomes (Calnan and Rowe, 2008).

How is the NHS performing?

The NHS has been under pressure for some time due to underinvestment, particularly during the years of austerity since 2010. But until recently, it continued to perform relatively well compared with healthcare systems in some other high-income countries such as Canada, France and the United States (although these are financed in different ways).

The NHS performs relatively well on assessments of equity, access to care and good value for money, but less well on health outcomes such as preventable deaths (Schneider et al, 2021).

The provision of free healthcare in the UK certainly protects the population from the precarious financial circumstances that can result from expensive healthcare bills in systems like that of the United States.

But these comparisons of performance are based on pre-Covid-19 data, and it will be important to see how the different healthcare systems have been affected by the pandemic.

Further, the health and life expectancy of the population is determined not just by outcomes related to the NHS, but also social and economic inequalities, for example, those related to nutrition.

What is the public's perception of the NHS versus private provision?

Survey evidence clearly shows that a majority of the public continues to support and is loyal to the NHS (Health Foundation, 2023; Buzelli et al, 2022). This applies both to the institution and the staff.

The value held for the NHS applies despite record increases in waiting times, the failure to meet performance targets and problems with staff recruitment.

Members of the public feel that the NHS needs more investment (Health Foundation, 2023; Buzelli et al, 2022). They want to have a better health service but not a different healthcare system. The NHS is still seen as a cherished, egalitarian institution that members of the public feel that they collectively own.

The NHS is seen to have value far wider than being an effective, universal healthcare system free at the point of access, and it has considerable social and political capital. Indeed, it has been suggested that healthcare systems do not just improve health, but that they can establish the social norms that shape human action and therefore act as a repository and producer of wider social value (Gilson, 2006).

These norms can help to establish a trusted, moral community, and they may provide the basis for more generalised social trust. This political capital was clear during the referendum campaign when Brexit supporters attempted to depict the value of leaving the European Union for the NHS on their campaign bus. It was also evident in government policies during the pandemic, when frontline workers were championed and portrayed as warriors.

In order to privatise the NHS, this close tie with the public would arguably need to be broken (Small, 2023). Underinvestment in the NHS, record waiting times and the reluctance of the government to negotiate with junior doctors over pay might be seen as an attempt to pursue that goal – in other words, a form of 'privatisation by stealth'.

Are people increasingly paying for healthcare?

Commodification has been part of the NHS for some time with the public paying, or co-paying, for services such as primary dental care. Recent research shows that the public, or some groups within the population, are now more likely to be willing to pay out-of-pocket for other areas of healthcare, including hospital care, particularly given current waiting times (Holmes, 2023).

This does not reflect a significant exit from the NHS – the level of private health insurance coverage of the population is estimated at around 7% (Anderson and Mossialos, 2022), with little evidence of a marked increase over recent years.

Recent survey evidence shows that 13% of Britons used private healthcare for themselves or an immediate member of their family in the last year. Further, just over a quarter of respondents (27%) considered private healthcare but did not pursue it on financial or other grounds, while the vast majority (57%) did not consider going private (Thomas et al, 2023).

The boundaries between private and public have become increasingly blurred with the NHS treating private patients, self-payment becoming normalised (Bayliss, 2022) and the private sector sometimes acting as a gateway into easier access to the NHS.

In 2019, NHS-funded patients accounted for around 30% of private hospitals' income (Anderson and Mossialos, 2022). On the other hand, in the same year, private patients accounted for less than 6% of NHS income (Bayliss, 2022).

This raises questions about social inequities in access to healthcare, as those with greater social and economic resources are more able to commute between the private sector and NHS care. As a result, while the private sector may be reducing pressure on the NHS, it is likely to exacerbate income inequalities in access to care.

Yet apart from the provision of 'hotel facilities', the quality of care may not be that different since the NHS and the private sector share the consultant, or specialist, workforce. Further, these individuals are usually trained in the public sector, which might be seen as a cost to the NHS and a drain on its resources.

The private sector operates in a more diversified market when it comes to nurses and other healthcare workers, with staff moving between the public and private sectors (Commission on the Future of Health and Social Care in England, CFHSC, 2014).

Recent survey evidence suggests that the increase in the numbers of patients paying for hospital care might be explained by health professionals recommending that their patients go private (Healthwatch, 2023). This appears to be due to concerns about their patients' health rather than because of commercial incentives or pressures (Edwards, 2022).

Conclusion

The costs of privatisation in its various guises could be significant. A more definitive analysis requires clear definitions of the concept and its operationalisation, as well as robust and consistent data to assess trends and their impact more accurately.

Where can I find out more?

- Commission on the Future of Health and Social Care in England: Final report and linked publications.
- *The NHS at 75: The State of UK Health Policy*: Book edited by Mark Exworthy, Russell Mannion and Martin Powell.
- Independent health care and the NHS: Report by Jonathon Holmes for the King's Fund.

- *Health Policy, Power and Politics: Sociological Insights*: Book by Michael Calnan.
- Public perceptions of health and social care: Research by the Health Foundation.
- The structure of the NHS in England: House of Commons Library research briefing.

Who are experts on this question?

- Michael Calnan
- Benjamin Goodair
- Carol Propper
- John Mohan

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Topics:
Health
Business
Public spending

Sidebar links:
How does the outsourcing of health and social care affect service quality?
Will the NHS long-term workforce plan solve the current crisis?
How is the cost of living crisis affecting public health?
How is the cost of living crisis affecting provision of social care?